An occupational therapy program for children and adolescents exposed to trauma

Cherie A. Lowe
University of North Dakota

Katie A. Tallackson
University of North Dakota

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AN OCCUPATIONAL THERAPY PROGRAM FOR CHILDREN AND ADOLESCENTS EXPOSED TO TRAUMA

by

Cherie A. Lowe, MOTS and Katie A. Tallackson, MOTS

Advisor: Sonia S. Zimmerman, MA, OTR/L, FAOTA

A Scholarly Project
Submitted to the Occupational Therapy Department
Of the
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In partial fulfillment of the requirements

for the degree of
Master’s of Occupational Therapy

Grand Forks, North Dakota
May 13, 2005
This Scholarly Project, submitted by Cherie A. Lowe and Katie A. Tallackson, MOTS in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

[Signature]
Faculty Advisor

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Title An Occupational Therapy Program for Children and Adolescents Exposed to Trauma

Department Occupational Therapy

Degree Master's of Occupational Therapy

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ABSTRACT

Every year many children and adolescents are affected by traumatic experience many of which result in long term challenges. The traumatic event may lead to psychological disorders, such as anxiety disorders, depression, oppositional defiant disorder, conduct disorder, substance abuse, and posttraumatic stress disorder (PTSD). These disorders often have the effect of interrupting development of occupational performance skills and ultimately are manifested in deficits in occupational performance. A literature review was conducted to identify the effects of trauma on children and adolescents as well as to explore current treatment programming available to this population. Examples of research-based occupational therapy programming for traumatized children and adolescents was reviewed.

An occupational therapy program is presented, including guidelines for therapists working with children and adolescents exposed to trauma. In addition, the program addresses the impact of the traumatic event on occupational performance, behaviors resulting from the traumatic event, and other long term occupational challenges. Within the context of developing and/or optimizing occupational performance skills, the program aims to (a) prevent further psychological problems, (b) establish skills to cope with the trauma, (c) alter social contexts to represent positive influences, (d) modify present performance barriers, and (e) create a safe environment that promotes trust and open communication. The referral process, suggested assessments, interventions, and
outcome measures are presented and demonstrate application of the Ecological Model of Human Performance to practice with children and adolescents exposed to trauma.
CHAPTER 1
INTRODUCTION

Every year many children and adolescents are affected by traumatic experiences which may result in long term challenges. Many of these experiences are due to abuse, neglect, natural disasters, traffic accidents, violence, terrorism, etc. Children and adolescents are negatively impacted by traumatic events they experience. Exposure to violence has been associated with low school achievement and high levels of anger, anxiety, aggression, antisocial behavior, and alcohol use (Boney-McCoy & Finkelhor, 1995). In addition to these individual effects, families and other individuals around them may also experience the impact. The traumatic events may also lead to psychological disorders, such as anxiety disorders, depression, oppositional defiant disorder, conduct disorder, substance abuse, and posttraumatic stress disorder (PTSD). According to Fletcher (2003), 36% of children exposed to traumatic events have PTSD. Despite this high percentage, many children and adolescents who have experienced trauma are left undiagnosed and untreated.

A need exists for an occupational therapy program specifically created to address children and adolescents who have experienced trauma. The proposed program will address the impact of the traumatic event, the behavior resulting from the traumatic event, and other long term challenges. The program will aim to (a) prevent further psychological and/or emotional problems, (b) establish and/or restore skills to cope with
the trauma, (c) alter contexts to represent positive influences, (d) adapt and/or modify the context or tasks to reduce performance barriers, and (e) create a safe environment that promotes trust and open communication.

Trauma is defined as “an experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects” (NIMH, 2001, Trauma – What is it?, ¶ 1). For the purpose of this program, children will be considered to be between 6 and 11 years of age and adolescents between 12 and 17 years of age. A comprehensive occupational therapy program for children and adolescents who have experienced trauma will be proposed for implementation. It will provide a structured plan for delivery of occupational therapy services to children and adolescents exposed to trauma. A description of the program, program objectives, application of the occupational therapy model, assessments, interventions, and outcome measures will be provided.

The next chapter presents a literature review conducted to explore current literature on this topic. The literature review will consist of information regarding post-traumatic stress disorder, impact of trauma, treatment approaches, occupational therapy treatment approaches, and a review of established treatment programs. The literature review will also identify and describe the Ecological Model of Human Performance (Dunn, Brown, & McGuigan, 1994), the occupational therapy model selected as a framework for the occupational therapy program for children and adolescents who have experienced trauma.
CHAPTER 2

LITERATURE REVIEW

This chapter provides a comprehensive review of the literature on trauma and posttraumatic stress disorder in children and adolescents. Topics included in the review are post-traumatic stress disorder, impact of trauma, treatment approaches, occupational therapy treatment approaches, and a review of treatment programs.

Posttraumatic Stress Disorder

Posttraumatic stress disorder is described as either acute or chronic in nature. Acute means symptoms are experienced less than three months and chronic means symptoms continue for more than three months. A diagnosis of PTSD includes meeting a set of specific criteria outlined in the DSM-IV-TR (2000): (a) person has been exposed to a traumatic event, (b) traumatic event is persistently re-experienced, (c) persistence avoidance of stimuli associated with the trauma, (d) persistent symptoms of increased arousal, (e) duration is longer than one month, and (f) disturbance causes impaired functioning. See Appendix for detailed PTSD diagnostic criteria.

According to Sadock & Sadock (2004) risk factors for developing posttraumatic stress disorder include age, socioeconomic status, gender, life events, and psychiatric comorbidity. Results of a study completed by Holbook, Hoyt, Coimbra, Potenza, Sise, and Anderson (2005) indicated older adolescents aged, 16 to 19 years had higher rates of PTSD than younger adolescents, aged 12 to 15 years. Study results indicated that family household with a low socioeconomic status was significantly associated with
long-term PTSD in adolescents. Finally, results indicated PTSD is higher in adolescent females (40%) than adolescent males (22%). In another study comparing adolescents from the United States to adolescents from Russia, the results found that in both countries, males reported lower levels of PTSD than females (Ruchkin, Schwab-Stone, Jones, Cicchetti, Koposov, & Vermeiren, 2005).

The nature of the trauma can have a significant impact on the development of PTSD in children and adolescents. Lipovsky (1991) found that “Children are more likely to develop PTSD if the traumatic event is violent, results in harm to the child or if the child witnesses the injury or death of a loved one” (p. 43). Similarly, Holbrook et al. (2005) found PTSD onset in adolescents was significantly associated with the death of a family member resulting from the trauma or no control over the event leading to trauma. It was also found that PTSD onset was significantly related to intentional or violence-related injuries (i.e. assault, gunshot wound, stab wound).

Trauma

Trauma is described as “an experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects” (NIMH, 2001, Trauma – What is it?, ¶ 1). The effects of trauma on children and adolescents may develop immediately following the incident or may appear weeks later (NIMH, 2001, How Children and Adolescents React to Trauma, ¶ 1). Review of the literature indicates the symptoms and effects of trauma may be categorized as psychological/emotional, behavioral, developmental, and familial.

Psychological/Emotional Impacts

Children and adolescents’ emotional development is often negatively affected by
Children and adolescents may begin to blame themselves for the traumatic event they experienced. This may lead to them feeling stigmatized and they may begin to avoid others (Cohen, Mannarino, Zhitova, & Capone, 2003). According to Lubit, Rovine, Defrancisci, and Eth (2003) trauma may affect the way that children view themselves as well as others. Children are particularly vulnerable because their personality and core identity are still being formed. Children may also experience feelings including but not limited to anger, distrust, fear, irritability, impaired self-esteem, emotional numbing, and hyperarousal.

Many people believe that children are not psychologically affected by trauma because they are too young to understand or remember the incident. Children are affected by trauma but their reaction is displayed differently depending on maturity and past experiences. Psychological effects of trauma on children and adolescents can develop into a variety of co-occurring problems. According to Lubit et al. (2003) exposure to violence can lead to a variety of problems including depression, anxiety disorders, and substance abuse. Steiner, Garcia, & Matthews (1997) found that oppositional defiant disorder and conduct disorder often result from a loss of impulse control and aggression. Another long-lasting effect of trauma is the development of posttraumatic stress disorder. According to a study completed by Famularo, Fenton, & Augustyn (1996) 40% of a group of severely maltreated children met diagnostic criteria for PTSD after they were removed from their homes. Two years later, 33% still met criteria for PTSD, signifying the long-lasting effects of PTSD on children and adolescents.

Behavioral Impacts
Behavioral impacts of traumatic events may vary for individuals depending on age and developmental stage. The NIMH (2001) divides children and adolescents into three groupings: children five years of age and younger, children six to eleven years of age, and adolescents twelve to seventeen years of age. The youngest group demonstrates behaviors such as crying, whimpering, screaming, immobility, trembling, and excessive clinging. These children also demonstrate regressive behaviors such as, thumb-sucking, bedwetting, and fear of darkness. The middle age group present with extreme withdrawal, destructive behavior, and inability to pay attention. In this group, regressive behaviors are also noted, such as nightmares, sleep problems, irrational fears, irritability, poor school attendance, anger, and aggression. The adolescent age group experience symptoms more similar to adults, including: flashbacks, nightmares, avoidance, substance abuse, and relationship problems. This age group may also experience suicidal thoughts, poor school attendance, and academic decline.

Familial Impacts

Traumatic events not only affect the individual but also the dynamics in the family. Parents may become distressed by their child’s change in behavior and may respond differently to the child. Parents may be more lenient on the child’s behavior following a traumatic experience due to the stress that has been placed on the child (De Arellano, Waldrop, Deblinger, Cohen, Danielson, & Mannarino, 2005). Parents often benefit from education regarding emotional and behavioral symptoms following a traumatic experience. This information may help the parents develop appropriate parenting skills as well as strategies to approach behavioral problems. Family support also has an impact on the children and adolescents reaction to trauma. Hamblen (n.d.)
reports lower level of PTSD symptoms in children and adolescents in families with greater support and coping skills.

Treatment

Posttraumatic stress disorder does not always require treatment, however according to Sadock & Sadock (2004) left untreated, “40% continue to have mild symptoms, 20% continue to have moderate symptoms, and 10% remain unchanged or become worse” (p. 237). Factors related to a good prognosis include rapid onset of symptoms, symptoms less than six months in duration, good premorbid function, strong social supports, and no prior psychiatric or medical disorders (Sadock & Sadock, 2004).

The first step in treating a child or adolescent who has experienced trauma is to recognize the need for possible treatment. Many parents, pediatricians, teachers, and counselors do not recognize the negative affects of trauma on children and adolescents and therefore the children go untreated. According to Ziegler, Greenwald, DeGuzman, & Simon (2005) “children with posttraumatic stress may be falling through the cracks because of the poor ability of families to recognize the problem, difficulties in applying diagnostic criteria, and less than optimal understanding by physicians” (p. 1265). It is important to identify and pursue the appropriate treatment methods needed immediately following a traumatic event.

Cognitive-Behavioral Therapy (Cognitive Therapy)

The research has indicated several treatment methods used in the treatment of trauma in children and adolescent. The NIMH (2005) identified cognitive behavioral therapy as an effective method of treatment. The goal of this type of therapy “is to change the person’s thoughts, which in turn will change the person’s behavior, ultimately
improving the client's daily function and sense of self-efficacy” (Bruce & Borg, 2002, p. 163). Cognitive behavioral therapy consists of teaching the patient methods of overcoming traumatic events and modifying undesirable behaviors. Patients are challenged to analyze and re-evaluate their beliefs that are hindering their treatment (NIMH). Following a traumatic event, patients have increased fear and often feel the event will happen again. For example, a patient may associate a distressed person with violence and a black cloud may be associated with another hurricane.

Cognitive behavioral therapy can be useful for parents of children and adolescents who have experienced a traumatic event. Parents often feel distress regarding their child’s experience and cognitive behavioral therapy allows the parents to directly address their feelings. De Arellano et al. (2005) report that therapists can encourage treatment follow-through at home by including the parents in the treatment process. However, King et al. (2000) report conflicting results. Thirty-six sexually abused children were randomly assigned to either a child-alone cognitive behavioral treatment or family cognitive behavioral treatment. Children involved in the child-alone treatment demonstrated improvements in PTSD symptomology including decreased fear and anxiety. Parental involvement in treatment was found to have no effects on the treatment.

Behavioral Therapy

Cognitive-behavioral therapy utilizes some behavioral techniques during treatment to change thoughts; behavioral therapy utilizes behavioral techniques to encourage change through reinforcement (Bruce & Borg, 2002). Techniques used in behavioral therapy include but are not limited systematic desensitization, therapeutic graded exposure, flooding, assertiveness training, aversion therapy, eye movement
desensitization and reprocessing, positive reinforcement, and dialectical behavior therapy (Sadock & Sadock, 2004).

A specific type of behavioral therapy that is often used for treating symptoms of trauma is exposure therapy. According to the National Center for PTSD (n.d.) “exposure uses careful, repeated, detailed, imaging of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma,” (Exposure therapy, ¶ 1). Exposure-based treatment is used with children and adolescents when memories or reminders of the trauma are distressing (Hamblen, n.d.). There are different forms of exposure therapy including: in vivo exposure and imaginal exposure. This treatment can be provided as prolonged exposure (flooding) or gradual exposure. Prolonged exposure introduces the victim to their traumatic experience at a faster pace and with greater intensity. Gradual exposure involves dealing with less intensity and gradually increasing the pace and intensity as therapy progresses.

Among the different types of exposure therapy, prolonged exposure (flooding) and gradual exposure have been given the most attention when treating victims of trauma (De Arellano et al., 2005). Gradual exposure has been found to reduce symptoms of PTSD in children who have been sexually abused (Cohen & Mannarino, 1997). It is important to include and recognize the value that exposure therapy may provide in treating children and adolescents who have experienced a traumatic event.

Parental Education/Training

Another important aspect of treatment in children and adolescents who have experienced trauma is parent education and training. Parents or caregivers often
minimize the symptoms and behaviors their children may be experiencing and ultimately
do not seek treatment unless encouraged by a professional. Because of this lack of
treatment, many children and adolescents are undiagnosed for PTSD and other related
disorders. For example, “Only 46% of parents actually sought assistance for their
children with diagnostic PTSD after traffic-related injuries” (de Vries, Kassam-Adams,
Cnaan, Sherman-Slate, Gallagher, & Winston, 1999, p. 1293). This statistic demonstrates
the role of parents in the treatment of their children.

Unfortunately, many parents do not play an active and supportive role which can
lead to poor outcomes for children and adolescents. Berkowitz (2003) strongly supports
the use of early intervention for children exposed to community violence. He describes
the role that early intervention could play in assisting and educating parents on childhood
trauma. Early intervention can provide parents with educational information on typical
reactions that children may experience, as well as helping the parents to understand
which behaviors they should be worried about. Berkowitz points out the importance of
helping the parents deal with their own difficulties in order to provide the best support for
their children.

Lubit et al. (2003) suggest that prior to treating the child, therapists need to
address how the parents are coping with the traumatic experience. If the parents are
depressed, anxious, or stressed, it is important to treat the parents prior to treating the
child. Lubit et al. (2003) describes a joint session with both the parents and child
involved. In this session the child can teach the parents what was learned in therapy, talk
about the impact of the trauma, and share work completed in therapy. Prior to this
session, it is recommended that the therapist meet with the parents to review what will
occur in the joint session. The joint session will allow the parents and child to work together and overcome problems related to the trauma.

De Arellano et al. (2005) created a community outreach program for child victims of traumatic events and describes the details of the program, including program overview, patient population, challenges to community-based work, and assessment. The treatment planning process consists of interventions such as parent training and education, relaxation training, coping skills, and exposure-based treatment. All children and families referred to this program receive educational information on prevalence of victimization, consequences of victimization, and possible treatment options. The beginning of the program also lays out the development of symptoms and treatment that may be beneficial. The authors feel that allowing the child and parents to collaborate in treatment improves overall compliance. Parent training in this community-based program (De Arellano et al., 2005) is provided in the home of the child or adolescent and it addresses noncompliance, oppositional and other undesirable behaviors. In-home parent training allows the therapist to see true interactions between parents and the child and allow the therapist to make suggestions and serve as a model. Parents are taught different techniques to reinforce positive behaviors using positive reinforcement and token economies. Undesirable behaviors are reduced using techniques such as selective ignoring and time out. Methods of redirecting children and adolescents are taught using clear instructions and consistency.

Programs

A combination of treatment approaches and theoretical models have been used in programs developed for the treatment of children and adolescent victims of traumatic
events. Three examples of treatment programs from the literature will be described: community-based outreach, community-based residential, and school-based. A fourth program is a community-based program for all members of a community.

**Mental Health for Immigrants Program (MHIP)**

The Mental Health for Immigrants Program (Stein et al., 2002) is a school-based program developed in Los Angeles County to meet the needs of recent immigrant students with mental health symptoms related to violence. The developers felt that immigrants to their community receive a variety of sources, however mental health services are lacking and barriers often prevent access to them. This program is built on the Behavioral Model for Vulnerable Populations theoretical model. “This model suggests health service is a function of a person’s predisposition to use such services, factors that enable or impede such use, the person’s need for care, and the same factors that make members of some populations vulnerable” (Stein et al., 2002, p. 320). Parents and teachers were provided with psychoeducation regarding the program as well as effects of violence on children. Home visits were also conducted with parents on an as-needed basis. To reduce access barriers, the students participated in eight cognitive behavioral therapy sessions that were conducted during school. The effectiveness of this program has not been reported, however continued funding and development indicate that it has been a success. The developers are hoping to extend this mental health program to the general student population to evaluate effectiveness as well.

**Residential Treatment Program**

Rivard et al. (2003) describe a residential treatment program which provides treatment for youth, 12 to 20 years of age, who have experienced maltreatment or been
exposed to family or community violence. The youth in this program also experienced emotional and behavioral problems. The treatment program consisted of three programs on one large campus. Each program included smaller residential units that served seven to sixteen youths. There were a total of twelve residential units and four of them implemented this specific program following the Sanctuary Model. The eight other units implemented a standard residential program. The goal of the Sanctuary Model was to teach effective adaptation and coping skills to replace nonadaptive strategies. This model also believed that a therapeutic environment is effective in facilitating the recovery process. It is believed that a therapeutic community is influential in treatment progression and that clients can facilitate each others progression. The interventions implemented in the Sanctuary Model included therapeutic community, community meetings, and psychoeducation exercises and groups. The results indicated that the Sanctuary Model was following a therapeutic community more closely than the standard residential program. No further outcome data was reported regarding the efficacy of the Sanctuary Model.

The Community Services Program (CSP)

This program was developed by Macy, Behar, Paulson, Delman, Schmid, and Smith (2004) as a community-based intervention that involved the community members in the recovery process. The developers believed that involving the community as a central role and assigning leadership roles to those who are able, will improve the effectiveness of the program. The program was designed to address both the psychological trauma of the events as well as the long-term psychosocial effects. This program was designed to "help community members identify and manage their traumatic
stress responses, fostering strength and safety, and potentially preventing traumatic situations from augmenting psychosocial degradation of the community” (Macy et al., 2004, p. 219). During the first 24 to 48 hours following a traumatic event, the CSP staff stabilized the situation by helping people feel safe. They also completed a community-based assessment to identify the individual’s specific needs. The interventions in this program included four steps: orientation sessions, stabilization groups, coping groups, and individual and dyadic sessions. Interventions were carefully structured and included techniques from cognitive-behavioral therapy, expressive therapy, play therapy, and mindfulness training. In addition to providing treatment interventions, CSP also trained approximately 260 people from local neighborhoods and schools to build a community network. A variety of outcome measures were used to assess the efficacy of this particular program. Community stakeholders were interviewed and all individuals expressed a high regard for the program. Ninety percent of all individuals interviewed stated that CSP was ready to respond and help around the clock. Seventy-nine percent stated they felt comfortable calling CSP to ask for advice or assistance. Forty-eight percent felt the program’s sensitivity to cultural differences was valuable. The developers felt that this program was beneficial because of the increased need for trauma response programs in communities.

Community Outreach Program – Esperanza

This community-based program developed by De Arellano et al. (2005) was created to provide services to children who are from underserved populations and who have experienced crime. The children and adolescents referred to this program were between the ages of two and seventeen years of age. Referrals were made for children
who were experiencing emotional and/or behavioral difficulties resulting from abuse, exposure to violence, and other violent crimes. An individualized treatment plan was prepared and discussed with the family of the clients following a comprehensive assessment. The interventions in this program included: psychoeducation for parents and children, parent training, relaxation training, coping skills, and exposure therapy. There was no outcome data available to assess the effectiveness of this program, however other clinicians have recognized the program as effective, resulting in more referrals.

Occupational Therapy

Occupational therapy (OT) is “skilled treatment that helps individuals achieve independence in all facets of their lives. It gives people the "skills for the job of living" necessary for independent and satisfying lives” (AOTA, 2005, What is Occupational Therapy?, ¶ 1). Kjorstad, O’Hare, Soseman, Spellman, and Thomas (2005) conducted a study on the effects of post-traumatic stress disorder on children’s social skills and play. In this study, the authors indicated the value of occupational therapy in this population by stating “occupational therapists have a thorough background in human development, play, and social interaction, which makes them vital members of the treatment team” (p. 41). The occupational therapist serves as a member of the treatment team by assessing and evaluating existing performance, setting therapeutic goals, developing a plan, and implementing treatment (Sabonis-Chafee & Hussey, 1998). “Occupational therapists have unique skills that are occupation centered in the balance of work, self-maintenance, and leisure, as well as the ability to address the psychosocial needs of socially underserved persons that cannot be fulfilled by other professionals” (Loukas, 2000, p. 10).
Occupational therapists use a client-centered approach that looks at the individual person and their goals for treatment. Using a client-centered approach, the individual helps to guide their therapy session by being involved with goal writing, treatment planning, and choosing interventions that are meaningful to them. To ensure effective treatment, occupational therapists address multiple aspects of the individual such as physical, mental, spiritual, and psychosocial aspects and the effects these aspects play in their ability to perform their desired occupations.

An occupational therapist can be found in a variety of settings including but not limited to: hospitals, clinics, schools, patient’s homes, community settings, and prisons. In each of these settings the OT addresses different areas of functioning. For example, in a community setting, an occupational therapist may assess an individual’s strengths and weaknesses and their ability to function effectively in the community. The treatment will focus on barriers that prevent the individual from successfully performing everyday tasks in their community. According to Loukas (2000) “the future of occupational therapy lies in the community” (p. 9). The expansion of occupational therapy into the community has allowed for the creation of more preventative programs. (Bruce & Borg, 2002).

OT Treatment

The focus of occupational therapy treatment with children and adolescents exposed to trauma is to decrease their stress related to the traumatic event and to promote healthy functioning and growth in the child or adolescent. Treatment is an essential part of the recovery process for the child or adolescent. According to the NIMH (2001) “PTSD may resolve without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur” (Post-Traumatic Stress...
Disorder, § 3). NIMH research has found that a reasonable time of treatment for PTSD is six to twelve weeks, with some follow-up sessions (2001).

Occupational therapists working in mental health can provide children and adolescents with services in a variety of settings including schools, inpatient hospitals, day treatment hospital programs, residential facilities, and community-based programs. In each of these settings the role of the occupational therapist in treatment may vary. For example, in the inpatient hospital setting the occupational therapy sessions are highly structured and focused on teaching new skills that can be applied later in the treatment continuum. In comparison, in a community-based program the occupational therapy sessions are structured with a focus on applying previously learned skills to increase the individual’s performance and participation in the community.

In mental health settings the occupational therapist is required to evaluate each individual and grade the treatment sessions to provide an appropriate amount of structure and challenge. Children and adolescents are at different levels of development and maturation and therefore require different treatment techniques for intervention to be effective. Children are developing self-identity and learning appropriate behavior and therefore require specific treatment concepts to assist in their continued growth and development. Adolescents are at a transitional stage of their life requiring them to apply previously learned information from childhood and new knowledge to be applied in adulthood. This transitional stage should provide more opportunities to learn, an increase in their independence, and a change of roles (Cara & MacRae, 2005).

Concepts that are important in treating children and adolescents include: structure, consistency, time-out, limit setting, avoidance of power struggles, modeling, and a
consistent team approach. Adolescents benefit from similar treatment concepts, however it is expected that less redirection and guidance will be needed from the therapist (Cara & MacRae, 2005). These concepts are a guide; however the group dynamics should be analyzed and considered when determining the extent of which treatment concepts are incorporated.

Davidson (2005) emphasized the importance of creating therapy goals that address social performance problems. The goals should relate directly to the wants and needs of the child and/or adolescent. During treatment the group members should be encouraged to evaluate their own performance in group sessions and identify areas to improve on. As the group members demonstrate progress the challenge of the group sessions increase to continue making treatment gains.

According to Cara & MacRae (2005), occupational therapy treatment with both children and adolescents utilizes a team approach which may involve, but is not limited to: family, teachers, psychologist, pediatrician, speech therapist, sports leaders, or community activity leaders. A team approach allows all team members to contribute to the individuals’ treatment goals and planning. It is important to keep in mind that consultation with other team members must be permitted by the child or adolescent, or the responsible parent (Cara & MacRae, 2005).

Occupational Therapy Programs

The review of literature yielded limited information regarding established mental health occupational therapy programs for children and adolescents. Two programs focusing on occupational therapy programming for children and adolescents were identified.
Hyter, Atchison, Henry, Sloane, & Black-Pond (2001) created an occupational therapy program to treat children who have experienced trauma. The Children's Trauma Assessment Center (CTAC) was located in southwestern Michigan and treated children traumatized primarily by abuse, neglect, and/or prenatal exposure to alcohol. The program offered comprehensive services and a transdisciplinary team approach for the treatment of children who have experienced trauma. Exposure to trauma impacts child development in a variety of ways. According to Hyter et al. (2001), "Child development domains affected include: physical, cognitive, sensory, and motor; behavior and emotional; and communication, including language and literacy acquisition" (p. 117).

The CTAC program (Hyter et al., 2001) was developed based on family centered and transdisciplinary practice. A family centered practice indicated that the family participated and contributed to the assessment and intervention process. It also emphasized the importance of considering the context and family dynamics surrounding the child and how they impact the child's behavior. A transdisciplinary approach involved multiple disciplines collaborating and working together to assess and treat the child. All team members shared responsibility and learned from each other regarding their area of knowledge. Disciplines involved with the CTAC program included counseling, occupational therapy, pediatric medicine, social work, and speech-language pathology.

According to Hyter et al. (2001) CTAC provided a variety of services. These services included assessment, recommendations, caretaker support, and advocating for services. CTAC provided a comprehensive assessment protocol. Areas included in the
protocol were medical examination, cognitive/academic, language/literacy, physical, emotional/behavioral, social/familial skills, and level of trauma. CTAC also hoped to increase communication between caretakers, educators, and social service workers to improve the treatment the child was receiving. A future goal of this program was to educate caregivers and educators on effective ways to work with children who have been exposed to trauma.

Two surveys were conducted, two years apart, to determine the community’s perceived need for the CTAC program. The surveys were mailed to human service professionals in counties in southwest Michigan. The survey results from 1998 indicated that 87 percent felt a strong to significant need for the program. The results in 2000 demonstrated a similar need by indicating that 80 percent felt a strong to significant need for the program. The CTAC opened in 2000 and has consistently received referrals from child welfare agencies and confirmed the need for this type of program. (Hyter et al., 2001)

Preventative Programming

This specific preventative occupational therapy community-based program was created for children surviving the Kosovo conflict. The established program was implemented in Gjakova, Kosovo, a city directly impacted by the conflict. The objective of this program was to prevent long-term psychological difficulties and to identify children who have developed further trauma in order to refer them for other services (Simo-Algado, Mehta, Kronenberg, Cockburn, & Kirsh, 2002).

The program was for six months and was designed and implemented by an occupational therapist and an occupational therapy student. The program was started in
five different schools and over 500 school-aged children between the ages of 6 and 14 participated in the program. The supervision provided by the occupational therapist and occupational therapy student was gradually reduced and the program was then run independently by the teachers.

This program (Simo-Algado et al., 2002) was based on a variety of principles including community-centered, transcultural and holistic occupational therapy, and meaningful occupations. Local community members were trained on how to conduct occupational therapy workshops with the children. Primary and secondary teachers were chosen to be the leaders of the workshops. The program consisted of three phases; theoretical training, practical training, and additional training. The role of the occupational therapist was to discuss with the teachers how to incorporate the training and activities they learned into the workshop. The occupational therapist also discussed techniques to use the activities to meet the therapeutic goals for the individual child.

According to Simo-Algado et al. (2002), interventions for the children focused on play and expression of feelings. “Use of play and expressive occupational workshops demonstrates the power of occupation and the value of occupational therapy intervention in helping children to successfully express and process traumatic emotions” (p. 212). The program resulted in more positive thoughts for the children. The progression the children made in dealing with war was evident in their drawings, play, and performances. The program also provided the opportunity for the children to support each other and express themselves.

Occupational Therapy Theory

The Ecological Model of Human Performance was developed by Dunn, Brown,
and McGuigan. "A primary purpose of the Ecology of Human Performance is to provide a framework that emphasizes the essential role of context in task performance" (Dunn, Brown, & Youngstrom, 2003, p. 223). This model is based on four constructs including person, context, task, and performance. Each person is viewed as unique and brings forth different experiences, values, interests, and skills. The task describes the behavior that the individual does to accomplish a goal. Context is divided into two categories temporal and environmental and can be viewed as either supporting or inhibiting of an individuals performance. The final construct focuses on performance which connects all four constructs together.

The interventions in the Ecological Model of Human Performance (Dunn, Brown, & Youngstrom, 2003) are guided by the individual’s needs and goals. The interventions focus on the individual as a whole, considering their whole situation and not only the identified problem. Five intervention approaches are identified when using the Ecological Model of Human Performance: establish/restore, adapt/modify, alter, prevent, and create. The models focus on natural context and the culture of the individual or community make this model well-suited with a community-based program.

Conclusion

The review of literature indicated that the impact of trauma on children and adolescents may affect different areas of their life. The areas found to be most commonly impacted were psychological/emotional, behavioral, developmental, and familial. The nature and severity of the trauma may have long-lasting effects and may contribute to the diagnosis of post-traumatic stress disorder. Hyter et al. (2001) suggested that a transdisciplinary team approach would provide a comprehensive
treatment program. The research also indicated several techniques that are beneficial in treating children and adolescents including structure, consistency, limit setting, modeling, and a consistent team approach (Cara & MacRae, 2005).

The review of literature found limited occupational therapy research focusing on trauma and post-traumatic stress disorder in children and adolescents. Occupational therapy research was also limited in the area of treatment and established mental health programs for this population. Therefore, a need exists for occupational therapy programs that focus on trauma and post-traumatic stress disorder in children and adolescents. As noted in the review of literature, few programs are currently established to address the needs of this population. Further, proposed programming needs to be based on established occupation-based models for practice. The Ecological Model of Human Performance will be used as a guide in the development of assessment and treatment procedures for children and adolescents who have experienced trauma.

Chapter three explores the methodology used in the development of the program focusing on trauma and post-traumatic stress disorder in children and adolescents. Chapter three also looks at the process used in designing the occupational therapy program including assessments and interventions for both children and adolescents receiving treatment.
CHAPTER THREE

METHODOLOGY

A literature review was conducted to identify the effects of trauma on children and adolescents as well as to explore current programming available to this population. The literature was gathered using a variety of search engines and indexes including OT Search, PubMed, and CINAHL. Review of the literature indicated a lack of literature related to program development in the field of occupational therapy for this population, therefore an occupational therapy based program for children and adolescents exposed to trauma was developed.

The development of this program was based on a combination of the occupational therapy process and the Ecological Model of Human Performance. In order to apply the Ecological Model of Human Performance to practice, the seven basic steps outlined in the model were followed (Dunn, Brown, & Youngstrom, 2003). The process began by developing a referral form for professionals in the community to refer the child or adolescent for treatment. The occupational therapy referral form was developed first in order to attain the patients.

Next, the assessments were either selected or created to provide information about the child or adolescent. Instruments developed for this program include a child/adolescent initial interview, parent/caregiver initial interview, parent/caregiver
satisfaction rating scale, and adolescent satisfaction rating scale. To begin developing these tools, text books from previous courses and departmental resources in the occupational therapy program were consulted. The child/adolescent initial interview and parent/caregiver initial interview were developed to gain an understanding of who the child or adolescent is and what areas they are struggling in as a result of being exposed to trauma. The parent/caregiver satisfaction rating scale and the adolescent satisfaction rating scale were developed to be used as an initial assessment tool as well as an outcome measure. All of the instruments were developed and adapted to meet the individual needs of the children and adolescents. The assessments were used as a means to explore the child or adolescent’s level of occupational performance.

The program objectives were developed utilizing the five intervention strategies outlined in the Ecological Model of Human Performance. These objectives were used in developing the suggested interventions to serve as a guide for therapists implementing this program. The suggested interventions were derived from activity resource books as well as created by the authors.

Chapter four presents the occupational therapy-based program developed for children and adolescents exposed to trauma. A detailed program description and occupational therapy protocol for the children and adolescents are provided. Instruments and interventions utilized for assessment, treatment, and outcome measures are also available.
CHAPTER FOUR

PRODUCT
An Occupational Therapy Program for Children and Adolescents Exposed to Trauma

By

Cherie A. Lowe, MOTS
and
Katie A. Tallackson, MOTS

Advisor:
Sonia S. Zimmerman, MA, OTR/L, FAOTA
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Program Description

Introduction

This program will provide a community-based occupational therapy program for children and adolescents exposed to trauma. It is recommended that the occupational therapy program run between six and eight weeks and include 6 to 8 individuals in each group. Children and adolescents exposed to trauma often have long-lasting effects in many areas of their life. Based on the information presented in the literature review, the effects may include psychological/emotional, behavioral, developmental, and familial. The goal of this program is to promote successful occupational performance in all contexts surrounding the child or adolescent. The goal will be addressed by using the Ecological Model of Human Performance and the four incorporated constructs: person, context, task, and performance to guide program development. See Figure 1 for program objectives that are based on the five intervention approaches used in the Ecological Model of Human Performance.

Figure 1. Program Objectives.

1) Prevent further psychological and/or emotional problems
2) Establish and/or restore skills to cope with the trauma
3) Alter contexts to represent positive influences
4) Adapt and/or modify the context or tasks to reduce performance barriers
5) Create a safe environment that promotes trust and open communication
Admission Criteria

Children between 6 and 11 years of age and adolescents between 12 and 17 years of age are eligible to participate in this program. Individuals must have experienced or been exposed to a traumatic event that has interfered with their functioning. A referral must be completed by a variety of individuals/professionals that could include but are not limited to teacher, psychologist, psychiatrist, pediatrician, primary care physician, parents/caregiver, and social services. See table of contents for referral form page number.

Assessment

Initial assessments were created to be administered to the child, adolescent, and parent/caregiver. These assessments will be used on the first day of services to gather background and relevant information for treatment. See table of contents for page numbers of initial assessment forms. Further assessment will be completed by the occupational therapist using the Occupational Therapy Psychosocial Assessment of Learning (OT PAL) and The Adolescent Role Assessment.

The Ecological Model of Human Performance (Dunn, Brown, & Youngstrom, 2003) evaluates four constructs person, task, context, and performance. The goal of the selected assessments is to incorporate these constructs to gain a better understanding of the child or adolescent. In the initial assessments the four constructs are incorporated throughout all sections. The person construct is addressed in areas such as personal interests, personal experiences, perception of self, and overall abilities. The task construct is addressed in the work/play/leisure section of the initial assessment. For example, when looking at work/play/leisure everything the child or adolescent chooses to
do with a goal in mind is considered a task. The context construct is divided into
temporal and environmental. It is addressed by looking at age, developmental stage, and
their physical, social, and cultural dimensions. The performance construct ties the
previous three constructs together. Several questions in the initial assessments are
focused on understanding the child or adolescent’s perception of their performance.

The Occupational Therapy Psychosocial Assessment of Learning (OT PAL)
developed by Townsend et al. (1999) will be administered to children ages 6 to 11 years.
The purpose of the assessment is to gain an understanding of the child’s psychosocial
development in comparison to their learning environment. The process of administering
the OT PAL assessment is divided into five steps including: (a) completing the pre-
observation and environmental description form, (b) conducting the observation in the
classroom, (c) using the rating scale and completing rating forms, (d) conducting the
teacher, student, and parent interviews, and (e) summarizing and interpreting the results.
The OT PAL will provide information to the therapist such as the student-environment
fit, the child’s social competence, and the child’s roles.

The OT PAL assessment (Townsend et al., 1999) primarily focuses on the
context construct of the Ecological Model of Human Performance. The assessment
examines the environmental issues that may positively or negatively impact the child’s
school performance. The person construct is addressed by looking at the child’s
cognitive abilities as well as their interests and values related to school. The task
construct is identified during the observation section and is considered to be any activity
the child completed within the classroom. The assessment will also evaluate the child’s
performance during the observation in the classroom. Also, the interview focused on the
childs, parents, and teachers perceptions of their performance. Performance will be further evaluated throughout the group sessions by the occupational therapists observations.

The Adolescent Role Assessment (Black, 1982) will be administered to adolescents between the ages of 12 and 17 years. The assessment is a semi-structured interview and is divided into six sections of developmental stages. The six sections are childhood play, family, school, peers, adolescent occupational choice, and adulthood work. The Adolescent Role Assessment focuses on the adolescent role changes experienced in the past, present, and future. The results are used in the treatment planning process to help the adolescent transition through the adolescent life stage.

The Adolescent Role Assessment (Black, 1982) focuses on all four constructs of the Ecological Model of Human Performance. The person construct is addressed by looking at their past, present, and future experiences. The assessment also incorporates the adolescent’s interests and values. The task construct is evident by the behaviors the adolescent identifies as important to complete their goals (i.e. homework, sports, home responsibilities, etc). Both temporal and environmental contexts are addressed in the assessment. Temporal context is found when looking at the adolescents developmental stages from their past to present and changes that have resulted. All areas of environmental context including social, cultural, and physical are evident in the sections such as play, family, school, peers, and work. The assessment is unable to evaluate performance however it focuses on the adolescents perceptions of their performance. Performance will be further evaluated throughout the group sessions by the occupational therapists observations.
See Reference page to access assessments.

**Application of the Model**

The Ecological Model of Human Performance is applied throughout the assessment and intervention process of the program. The four constructs of the model were incorporated throughout the assessments as previously written. The interventions will follow the five identified strategies of the Ecological Model of Human Performance.

In order to apply the Ecological Model of Human Performance to practice, Dunn, Brown, & Youngstrom (2003) suggest following seven basic steps as outlined in figure two.
Figure 2. The Ecological Model of Human Performance Seven Basic Steps

<table>
<thead>
<tr>
<th>Steps</th>
<th>Program Application</th>
</tr>
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<tbody>
<tr>
<td>1. Prioritize the individual’s/populations wants and needs</td>
<td>Initial Assessments (children, adolescent, parent)</td>
</tr>
<tr>
<td>• Identify and prioritize tasks that the person(s) considers most important</td>
<td></td>
</tr>
<tr>
<td>• Include task priorities of significant others and organizations or systems that interface with the person(s)</td>
<td></td>
</tr>
<tr>
<td>2. Analyze prioritized tasks</td>
<td>Observation of tasks (group sessions, school, home)</td>
</tr>
<tr>
<td>• Analyze a task to understand its skill requirements and demands</td>
<td></td>
</tr>
<tr>
<td>3. Evaluate performance</td>
<td>Initial Assessments (children, adolescent, parent)</td>
</tr>
<tr>
<td>• Understand how the task is performed differently by this person(s) and what contributes to difficulty of performance</td>
<td></td>
</tr>
<tr>
<td>• Understand how this person(s) views proficiency. What is the acceptable level of performance for this person?</td>
<td></td>
</tr>
<tr>
<td>4. Evaluate the contexts</td>
<td>Initial Assessment (parent)</td>
</tr>
<tr>
<td>• Understand the contextual features of the client’s situation</td>
<td></td>
</tr>
<tr>
<td>• Identify the contexts in which prioritized tasks occur</td>
<td></td>
</tr>
<tr>
<td>5. Evaluate the person/population variables</td>
<td>Initial Assessments (children, adolescent)</td>
</tr>
<tr>
<td>• Specifically assess the person variables which hinder and support performance in prioritized areas or tasks</td>
<td></td>
</tr>
<tr>
<td>6. Develop goals and choose intervention strategies for identified priorities</td>
<td>Treatment planning process</td>
</tr>
<tr>
<td>7. Evaluate the person/task/context match and select achievable goals and reasonable intervention strategies</td>
<td></td>
</tr>
</tbody>
</table>

Interventions

The interventions in this program are divided into two groups, children and adolescents. Suggested interventions will be provided for each of the groups following the five intervention strategies addressed in the Ecological Model of Human Performance (Dunn, Brown, & Youngstrom, 2003). The intervention strategies include establish/restore, alter, adapt/modify, prevent, and create. Establish/restore is the only approach focused on changing the person by establishing new skills and abilities in the person or restoring skills and abilities that were lost. Adapt/modify involves making changes to the environment and task. Adapt strategies are often aimed at physical contexts however also include social, cultural, and temporal contexts. The alter approach does not change the person or the environment but matches the person with the best fitting environment. Create does not assume that a disability is present. The goal of create strategies is to enhance performance and finally, prevent is utilized to avoid potential problems and further disability.

The intervention strategies are intended to be used as a guideline for treatment however the strategies used shall be determined by the needs of the group. The therapist will be responsible for evaluating the group dynamics and determining the appropriate intervention strategy to be used in each session. The therapist is encouraged to be familiar with the strategies in order to make the best decisions.

Outcome Measures

Three outcome measures will be used to evaluate the effectiveness of the program. A parent/caregiver rating scale was developed to address the parent/caregiver perception of their child’s and/or adolescent’s role performance and the parent/caregiver satisfaction with their performance. The rating scale includes ten statements that the
parent/caregiver will rate using a five-point Likert scale. The rating scale will be administered to the parent/caregiver at the initial interview as well as the exit interview.

A client's satisfaction survey will be given to the adolescents at the end of each treatment week. The adolescents will be required to rate their satisfaction on a five-point Likert scale regarding the group sessions and their participation in group. The survey will not be administered to the children, as their developmental stage may affect their ability to reflect on their performance and report accurate satisfaction.

The OT PAL assessment (Townsend et al., 1999) will be administered to the parent/caregiver and teacher at the initial interview as well as the exit interview. The OT PAL assessment will provide information regarding any changes in the child's psychosocial development in comparison to their learning environment. The assessment will also help to monitor any changes in the child's behavior and learning.
Occupational Therapy Protocol for Children

Ages 6-11
Protocol for the Treatment of Children

1. Referral Form

2. Assessments
   • Child Initial Interview
   • Parent/Caregiver Initial Interview
   • Parent/Caregiver Satisfaction Rating Scale
   • OT PAL Assessment

3. Suggested Interventions
   • Establish/Restore
   • Prevent
   • Adapt/Modify
   • Create
   • Alter

4. Outcome measures
   • Parent/Caregiver Satisfaction Rating Scale (same as above)
   • OT PAL Parent/Caregiver and Teacher Rating Scale (same as above)
Occupational Therapy Referral Form

Child/Adolescents Name: _______________________________________________________

Date of Birth: __________ Age: _________ Gender: _________

Parent/Caregiver Name: ______________________________________________________

Parent/Caregiver Phone Number: ____________________________________________ (Home)

________________________________________ (Work)

Diagnosis: _________________________________________________________________

Current Allergies: __________________________________________________________

Current Medications: ________________________________________________________

Reason for Referral:
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

Referral Source:

☐ Parent
☐ Pediatrician
☐ Primary Care Physician
☐ Psychiatrist
☐ Psychologist
☐ Social Services
☐ Teacher
☐ Other _______________________

_____________________________ Referring Individual Signature ______________________ Date
CHILD INITIAL INTERVIEW

Biographic Information

How old are you? _______ When is your birthday? _______

Where do you live (rural/urban/suburban)? _______

What is the street address? _______________________________________

Home

Who lives in your house? What are the ages of siblings?

How do you feel you get along with your siblings and parents? Explain.

Do you have any pets?

What is your room like?

What chores do you do at home?

Does your mother/father work? What does your mother/father do at work?

What do you do at home that gets you in trouble?

Who gets mad at you when you get in trouble? What do they do?

What does your mother/father do that gets you mad? What do you do?

What holidays/traditions are important to your family? How do you celebrate them?

School

What grade are you in school?

What do you like most about school? What do you like least about school?

Do you ever miss school? If so, why?

How do you feel you are doing in school? Explain.

Peers

Who is your best friend? What activities do you like to do with him/her?

Who are some of your other friends? How do you think your friends would describe you?

Is there anyone around your house or at school that you do not like?

Why don’t you like him/her?
**Work/Play/Leisure**

What do you do after school? What kind of games do you like to play?

What do you do on weekends?

Do you have any hobbies?

**Personal Here and Now Status**

Why are you here?

What do you want to change while you are here?

Tell me something good about yourself.

If you could change anything about yourself by wishing, what would it be?

Length of Interview: ____________

**Observations**

Good/poor eye contact
Cooperative/uncooperative
Appeared comfortable/uncomfortable
Easy/difficult to obtain responses to questions
Direct/rambling responses
Information reliable/unreliable

**Additional Comments/Observations**

Therapist: ____________________________ Date: ________________

PARENT/CAREGIVER INITIAL INTERVIEW

Biographic Information
How old is your child? ________    When is their birthday? ________

Home
What is your child’s living situation? Do you have any other children?
What chores does your child do at home?
Do you work? If so, where do you work? How many hours per week?
How many hours per day do you spend with your child?
What does your child do at home that gets him/her in trouble?
Who does the disciplining of the child? What kind of discipline do they use?
What holidays/traditions are important to your family? How do you celebrate them?

School
What grade is your child in school? How does your child feel about school?
Have you noticed a change in their school performance?
Does your child need help with homework?
Does your child ever miss school? If so, why?
Has your child been in trouble at school? If so, what happened?
Does your child participate in school activities?

Peers
Who does your child spend time with? What activities do you they do together?
Do you approve of your child’s friends? Why or why not?
Does your child express concern about other peers?

Work/Play/Leisure
What does your child do after school? What does your child do on weekends?
What are your child’s interests?
If appropriate, does your child have a job? If so, where?
How does your child feel about working? Explain.

Have you noticed a change in your child’s interests?

**Personal Here and Now Status**

Tell me about your child’s traumatic experience.

How long ago did your child experience the trauma? How long did the trauma last?

Have you noticed any changes in your child since the trauma?

What do you hope will change in your child from participating in this program?

Length of Interview: ____________

**Observations**

Good/poor eye contact
Cooperative/uncooperative
Appeared comfortable/uncomfortable
Easy/difficult to obtain responses to questions
Direct/rambling responses
Information reliable/unreliable

**Questions/Additional Comments/Observations**

Therapist: __________________________ Date: ______________

Child’s Name__________________________
initial__ date________
exit____ date_____

PARENT/CAREGIVER SATISFACTION RATING SCALE

Please circle the number that most clearly reflects your observations.

| A. Rate your child’s/adolescent’s current performance as a family member. |
|-----------------------------|-----------------------------|
| Poor | 2 | 3 | 4 | 5 | Great |

| B. Rate your satisfaction with your child’s/adolescent’s current performance as a family member. |
|-----------------------------------------------|-----------------------------|
| Unsatisfied | 2 | 3 | 4 | 5 | Extremely satisfied |

| C. Rate your child’s/adolescent’s current performance at school. |
|---------------------------------------------------------------|-----------------------------|
| Poor | 2 | 3 | 4 | 5 | Great |

| D. Rate your satisfaction with your child’s/adolescent’s current performance at school. |
|-----------------------------------------------|-----------------------------|
| Unsatisfied | 2 | 3 | 4 | 5 | Extremely satisfied |

| E. Rate your child’s/adolescent’s current performance in peer participation. |
|-----------------------------------------------|-----------------------------|
| Poor | 2 | 3 | 4 | 5 | Great |

| F. Rate your satisfaction with your child’s/adolescent’s current performance in peer participation. |
|-----------------------------------------------|-----------------------------|
| Unsatisfied | 2 | 3 | 4 | 5 | Extremely satisfied |

| G. Rate your child’s/adolescent’s current performance in play/leisure activities. |
|-----------------------------------------------|-----------------------------|
| Poor | 2 | 3 | 4 | 5 | Great |

| H. Rate your satisfaction with your child’s/adolescent’s current performance in play/leisure activities. |
|-----------------------------------------------|-----------------------------|
| Unsatisfied | 2 | 3 | 4 | 5 | Extremely satisfied |

| I. If applicable, are you aware of any problems with your adolescent at work? |
|-----------------------------------------------|-----------------------------|
| None | 2 | 3 | 4 | 5 | Many problems |

Comments: ________________________________________________________________

_____________________________________________________________________

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OT PAL Assessment

The Occupational Therapy Psychosocial Assessment of Learning (OT PAL) developed by Townsend, S., et al. (1999) will be administered to children ages 6 to 11 years. The purpose of the assessment is to gain an understanding of the child’s psychosocial development in comparison to their learning environment. The process of administering the OT PAL assessment is divided into five steps including: (a) completing the pre-observation and environmental description form, (b) conducting the observation in the classroom, (c) using the rating scale and completing rating forms, (d) conducting the teacher, student, and parent interviews, and (e) summarizing and interpreting the results. The OT PAL will provide information to the therapist such as the student-environment fit, the child’s social competence, and the child’s roles.

To access the OT PAL assessment, use this reference or the internet website at www.moho.uic.edu.

Establish/Restore
**Program Objective:** Establish and/or restore skills to cope with the trauma

**Intervention Strategy Addressed:** Establish/Restore

**Age group:** Children (6-11)

**Goal of group session:** Learn how to create and use “I feel” statements.

**Title of group session:** “My Feelings”

**Materials needed:** “My Feelings” worksheet (see attached) and pencils

**Instructions:** Share your feelings by completing the following “I feel” statements.

**Activity:** Distribute the worksheets and give instructions.

**Possible Discussion Areas/Questions:**
1. Which “I feel” statement was the easiest to make? Why?
2. Which “I feel” statement was most difficult to make? Why?
3. Talk about the different feelings stated in the “I feel” statements.
4. Describe other feelings you have had.

“My Feelings”

1. I feel happy when ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________.

2. I feel sad when ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________.

3. I feel frustrated when __________________________________________________________
   ________________________________________________________________
   ________________________________________________________________.

4. I feel scared when _____________________________________________________________
   ________________________________________________________________
   ________________________________________________________________.

5. I feel angry when _____________________________________________________________
   ________________________________________________________________
   ________________________________________________________________.

6. I feel proud when ______________________________________________________________
   ________________________________________________________________
   ________________________________________________________________.

**Program Objective:** Establish and/or restore skills to cope with the trauma

**Intervention Strategy Addressed:** Establish/restore

**Age group:** Children (6-11)

**Goal of group session:** To process the concept of trust through storytelling.

**Title of group session:** “Tommy’s Story”

**Materials needed:** “Tommy’s Story” worksheets (see attached), pencils, crayons, markers, and colored pencils

**Instructions:** Instruct the children to read or listen to the story about Tommy. After reading the story, instruct the children to complete the questions and draw a picture.

**Activity:** Distribute the worksheet and give instructions.

**Possible Discussion Areas/Questions:**
1. What do you think about the story?
2. What does trust mean to you?
3. Have there ever been people whom you feel you can trust? Why or why not?
4. Is there anyone you feel you can trust? Why or why not?
5. Tell me about your picture.

Activity #33: Tommy’s Story

• Read or listen to the story and answer the questions.

Tommy just had his birthday. He was now 10 years old. He was happy he was getting bigger. Still, he was not nearly as big as his brother, Bruce, who was 14 years old. Bruce was really big and used this to get Tommy to do what he wanted him to do.

Tommy hated it when Mom and Dad used to go shopping on the weekends or go to a meeting at school during the week, because Bruce would be left “in charge.” Bruce used to make Tommy rake all the leaves in the backyard and clean the dog messes, even though it was his job. If Tommy refused or said he would tell Mom or Dad, Bruce would hit him and threaten to hurt him really bad if he told.

One day, Tommy was tired of always doing what Bruce ordered him to do, so he said “no.” Bruce started beating up Tommy. He kept hitting his head on the ground. Tommy had a big bump and bruises on his head. When his parents got home, Bruce said Tommy fell off his bike.

Tommy was afraid to tell. Bruce would always apologize to Tommy, saying he was sorry and that he would never do it again... but Bruce always broke his promise.

QUESTIONS

1. Could Tommy trust Bruce in the story? Why?

2. Is there anyone you can trust? Who? Why?

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Program Objective: Establish and/or restore skills to cope with the trauma

Intervention Strategy Addressed: Establish/restore

Age group: Children (6-11)

Goal of group session: To confront the trauma by means of drawing a picture and writing about being hurt and developing a book.

Title of group session: “My story”

Materials needed: Drawing paper, pencils, crayons, markers, colored pencils, and string

Instructions: Instruct the children to think about their traumatic experience. Have the children begin drawing pictures or writing and/or dictating their story. After the children complete their stories encourage them to design a cover for the book. Then put all the pages together including the front and back covers. You can use paper fasteners, string, or cord to complete the book.

Activity: See above

Possible Discussion Areas/Questions:
1. Tell me about your book.
2. Do you want to read it?
3. What did it feel like telling your story?
4. How do you feel putting your story in a book or on paper? Why?

Program Objective: Establish and/or restore skills to cope with the trauma

Intervention Strategy Addressed: Establish/restore

Age group: Children (6-11)

Goal of group session: To continue processing any sad/scared/angry feelings that remain unresolved.

Title of group session: “My sad/scared/angry feelings”

Materials needed: “My sad/scared/angry feelings” worksheet (see attached), pencils, crayons, markers, and colored pencils

Instructions: Instruct the children to think about the things that are still making sad/scared/angry feelings. After having the children think about these feelings, have them draw pictures or list them. After they have identified them have them complete the “I feel” statements.

Activity: Distribute worksheet and give directions.

Possible Discussion Areas/Questions:
1. Tell me about the things that are still making sad/scared/angry feelings for you.
2. What do you want to do with these sad/scared/angry feelings?
3. Tell me about your “I feel” statements.

Activity #63: My Sad Feelings

- Think about the things that are still causing sad feelings. Then draw a picture or list the things that still make you sad.

- Fill in the "I feel" statements for the things that still cause sad feelings:

I feel sad when:

I feel angry when:

I feel scared when:

Prevent
Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Children (6-11)

Goal of group session: To begin addressing guilt and shame associated with trauma and self-blame.

Title of group session: “Thinking it was my fault”

Materials needed: “Thinking it was my fault” worksheet (see attached) and pencils

Instructions: Instruct the children to read the sentences and complete them, stating why they feel the trauma was their fault. Make modifications if needed, such as reading the statements and having the child complete them

Activity: Distribute worksheets and give directions.

Possible Discussion Areas/Questions:
1. How do you feel about your sentences? Why?
2. What does fault mean to you?
3. Was this activity hard or easy for you? Why?
4. Discuss each sentence.

Activity #58: Thinking It Was My Fault

- Complete the following sentences.

1. Sometimes I believe it was my fault because

2. Sometimes I believe it was my fault because

3. Sometimes I believe it was my fault because

4. Sometimes I believe it was my fault because

---

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Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Children (6-11)

Goal of group session: To develop rules that will assist in safeguarding against experiencing any future trauma.

Title of group session: “Safety Rules”

Materials needed: “Safety Rules” worksheet (see attached), pencils, crayons, markers, and colored pencils

Instructions: Instruct the child to read or listen to the listed rules. Have the child draw or list three additional ways to keep himself or herself safe. Encourage discussion of ways to keep safe.

Activity: Distribute worksheet to each child and give directions.

Possible Discussion Areas/Questions:
1. How do you feel about the rules listed?
2. Which rule do you feel is the safest? Why?
3. Tell me about your rules.
4. How will your rules keep you safe?

Activity #37: Safety Rules

- Read the following rules to keep yourself safe.

1. It is ok to say "no" to someone who wants to get in your personal space.

2. It is ok to express any feeling, as long as you do not hurt anyone or anything.

3. Keep a safe distance from strangers or people who make you feel uncomfortable.

List three more ways to keep yourself safe:

1. 

2. 

3. 

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Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Children (6-11)

Goal of group session: To develop a plan to appropriately express and work through difficult feelings.

Title of group session: “My contract”

Materials needed: “My contract” worksheet (see attached) and pencil

Instructions: Instruct the children to think about the different ways of expressing feelings that have been explored during previous group sessions. Have the children identify specific ways that would help them to express their feelings. Use the activity form to write the ideas into a contract. Modifications may be needed, such as some children may need to dictate their responses instead of writing.

Activity: Distribute worksheets to each child and give directions.

Possible Discussion Areas/Questions:
1. Tell me about your contract.
2. What do you think might get in the way of doing some of these things? Why?
3. What things do you think will be the most helpful? Why?

Activity #67: My Contract

- Complete the following contract.

I will take care of my angry, hurt, and sad feelings by:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Signed by ________________________________________________

Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Children (6-11)

Goal of group session: To begin discussing the concept of secrets through storytelling and to help children differentiate between safe and unsafe secrets.

Title of group session: “Samantha’s Story”

Materials needed: “Samantha’s Story” worksheet (see attached), pencils

Instructions: Instruct the children to read or listen to the story of Samantha. After reading the story, instruct the children to complete the questions related to the story.

Activity: Give each child a copy of the attached worksheet and give instructions.

Possible Discussion Areas/Questions:
1. What do you think about the story?
2. What is the difference between safe and unsafe secrets?
3. Give me an example of a safe and unsafe one.
4. How did you feel about Samantha’s secret?
5. Have you ever had a secret that you thought you shouldn’t tell?

Activity #38: Samantha’s Story

• Read or listen to the story and answer the questions.

Samantha was 11 years old. She thought she was old enough to go to summer camp like her friends. Instead, her mother told her that she was going to stay with her grandparents again. This made Samantha very upset. She didn’t like going there anymore. The summer was a hard time for her mother because her mother and stepfather got divorced. She depended on her parents to watch Samantha and her younger sisters.

Samantha hated leaving the neighborhood where she spent her time playing with her best friend, Jarnie, who lived in the same apartment building. She especially hated the “special” times when her grandfather would take her fishing. It was there when he first touched her in her “private places.” He told her that it was their “secret” and that no one would believe her if she told. Samantha was confused. She used to like the special times they spent together but wished he would not touch her that way anymore.

As Samantha packed to go to her grandparents, she wondered if her grandfather did anything like that to her mother. She wondered if she should tell her mother. After all, this wasn’t a fun secret like Jarnie’s birthday party.

QUESTIONS

1. What is the difference between safe and unsafe secrets?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
2. What was the fun or safe secret in this story?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. What was the unsafe or difficult secret in this story?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4. What do you think Samantha should do?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Adapt/Modify
Program Objective: Adapt and/or modify present context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Children (6-11)

Goal of group session: To improve the parent-child interaction by engaging them together in pleasurable, successful activity.

Title of group session: Parent-child activity group

Materials needed: A variety of activities available for the children and parents to chose.

Instructions: Report the goals of the group to the children and the parents. Instruct each parent-child group to choose an activity together to work on with the goal of completing in one group session.

Activity: Parent-child activity group

Possible Discussion Areas/Question
1. What did you like about working on this activity? Why?
2. What did you not like about working on this activity? Why?
3. How did you feel when working on the activity? Why?

Program Objective: Adapt and/or modify present context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Children (6-11)

Goal of group session: To nurture oneself by promoting comfort and a secure sense of healing.

Title of group session: “Safe-Place”

Materials needed: “Safe-Place” worksheet (see attached), pencils, chalkboard/whiteboard, markers, crayons, and colored pencils

Instructions: Distribute handouts to all children and read the entire page to help the group members understand the concept. List on the chalkboard/whiteboard things that come to mind when “teddy bear” is mentioned. Continue with each word on the activity sheet. Instruct each child to draw or write what belongs in his/her safe-place. Share as a group and then plan how to create this safe-place in their homes.

Activity: Distribute worksheets and give directions.

Possible Discussion Areas/Questions:
1. What does it mean to create a safe-place?
2. Describe your safe-place.
3. How are you going to create your safe-place in your home?

Safe-places promote comfort and a sense of healing. It is important to create a sense of security in your everyday life. One way of doing this is to first create a safe-place on paper. Then, you can create a safe-place in your living situation by taking the images and symbols from the paper safe-place to your actual safe-place.

Draw or symbolize in words or pictures what comes to your mind when you think of...

• warmth
• a cuddly blanket
• a teddy bear or other stuffed animal
• someone that you trust
• something that you trust
• a color that is soothing
• a scent that is comforting
• moments from the past that were safe and comforting

Actual safe-places are created in living environments (corners, windows, nooks, etc.), or any other place that helps you to feel safe.

Program Objective: Adapt and/or modify present context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Children (6-11)

Goal of group session: To gain an understanding of personal space.

Title of group session: “Personal Space”

Materials needed: “Personal Space” worksheet (see attached), crayons, markers, and colored pencils

Instructions: Instruct the children to color in the personal space noted on the worksheet. As the children are working on coloring in the personal space, discuss what this space means to each person.

Activity: Give each child a copy of the attached worksheet and give instructions.

Possible Discussion Areas/Questions:
1. Tell me about your personal space.
2. What is your personal space?
3. How do people violate personal space?
4. What happens when people violate someone's personal space?
5. How has your personal space been violated?

Activity #21: Personal Space

- Color in the personal space.
Program Objective: Adapt and/or modify the context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Children (6-11)

Goal of group session: To teach children to use imagery techniques when their environment is negatively impacting their ability to perform an identified task.

Title of group session: “Imagine utopia”

Materials needed: Chairs and CD or cassette tape if needed

Instructions: At the beginning of the group session have all children meet together to discuss rules, purpose, and goals for the upcoming imagery session. Explain the activity and state that the group will meet at the end to process the experience.

Activity: The children should be sitting in chairs to encourage their participation with the session. Instruct the children to close their eyes and listen. The group protocol can be either on CD/tape or the therapist can dictate it. Encourage the children to use all senses during the imagery. Lead the children through a variety of situations requiring vivid imagery.

Possible Discussion Areas/Questions:
   1. How did it feel to close your eyes and listen for that length of time?
   2. What types of things did you imagine?
   3. What was most difficult during the imagery session?
   4. How can these techniques that you learned be used during daily life?
Create
Program Objective: Create a safe environment that promotes trust and open communication

Intervention Strategy Addressed: Create

Age group: Children (6-11)

Goal of group session:
1) Provide a stimulating environment where the children will be motivated to play.
2) Encourage peer interaction through play.
3) Provide insightful interpretations related to the play when appropriate.
4) Allow the children to work through dynamic issues through the play.
5) Encourage the highest developmental level of play and interpersonal interaction possible.

Title of group session: Play Group

Materials needed: Toys, water and sand areas, dress-up clothes, table and chairs, etc.

Instructions: Explain group rules to the children and allow them and encourage them to play.

Activity: Play group should be held at a location that is feasible and open to all members of the community. The group should be advertised and ages should be defined prior to the play group. The play group should be discussed at the next treatment session.

Possible Discussion Areas/Questions:
1. What did you like about play group? Why?
2. What did you not like about the play group? Why?
3. What was difficult about being in the play group? Why?

Program Objective: Create a safe environment that promotes trust and open communication

Intervention Strategy Addressed: Create

Age group: Children (6-11)

Goal of group session: To increase interaction and participation in a leisure activity with individuals at a designated skilled nursing facility (SNF).

Title of group session: “Hands Across Generations”

Materials needed: Transportation to the SNF and materials needed to complete the chosen leisure activity

Instructions: Meet with the children prior to departing for the SNF to discuss the rules, purpose, and goals of the treatment session. Give each child the name of their “buddy” at the SNF. State that upon arrival back at the occupational therapy department a short time period will be used to process the group session.

Activity: The activity should be chosen and materials should be purchased prior to the day of this treatment session. Examples of activities include: bingo, puzzles, craft projects, card making, seasonal activities (pumpkin decoration, caroling, baking/decorating cookies), etc.

Possible Discussion Areas/Questions:
1. What did you must enjoy during this session?
2. What was most difficult about this session?
3. What did you learn from the experience?
4. What other activities would you like to complete with your “buddy”??
Program Objective: Create a safe environment that promotes trust and open communication

Intervention Strategy Addressed: Create

Age group: Children (6-11)

Goal of group session: To increase the awareness and knowledge of community members regarding trauma in children.

Title of group session: “What is trauma?”

Materials needed: Facility with stage and chairs, decorations, props, programs to handout, etc.

Instructions: This activity will require approximately one month planning and ultimately carry-out. Describe the goal of the activity to the children and brainstorm for ideas. Encourage excitement in the children and explain the opportunity they have to educate the community about trauma.

Activity: The children in the treatment program will create and put on a presentation that will be given to community members. The purpose of the presentation is to increase awareness and knowledge about trauma and how it impacts the lives of children. Ideas that may be incorporated include: puppetry, musical performances, acting, poetry, etc.

Possible Discussion Areas/Questions:
1. What was the most difficult part of planning the presentation?
2. What did you enjoy about this activity?
3. What did you learn from preparing and putting on the presentation?
4. How can you continue to educate others about trauma?
5. How do you feel the overall presentation went?
6. What do you think the community members most enjoyed?
**Program Objective:** Create a safe environment that promotes trust and open communication

**Intervention Strategy Addressed:** Create

**Age group:** Children (6-11)

**Goal of group session:** To promote awareness in community members about trauma and the effects of trauma in children.

**Title of group session:** “Community Awareness”

**Materials needed:** Paper, computers, video camera, etc.

**Instructions:** As a group brainstorm ideas of how to increase awareness in the community about trauma and the effects of trauma. Ideas may include pamphlets, posters, newspaper articles, videos, etc. Ask the group members what information they feel is important for the community to know.

**Activity:** After brainstorming ideas and agreeing on methods to communicate their ideas, break into small groups (3-4 people) and begin working. This activity will also require team work and collaboration. When the activity is completed, distribute the products to community members.

**Possible Discussion Areas/Questions:**
1. What was most difficult about this activity?
2. What did you enjoy about this activity?
3. What other ways can you individually increase community awareness?
4. What do you wish the community members would understand about you?
Alter
Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Children (6-11)

Goal of group session: To identify various means of support and establish a plan to utilize designated support systems more effectively.

Title of group session: “What are your lifesavers?”

Materials needed: “What are your lifesavers” worksheet (see attached), pencils, and chalkboard/whiteboard

Instructions: Introduce the topic of “lifesavers” and support systems. Lifesavers can be individuals or other things such as sleep, exercising, eating healthy, etc. Brainstorm ideas on a chalkboard/whiteboard. Distribute handouts and encourage children to complete. Share responses as a group.

Activity: Distribute worksheets and give directions.

Possible Discussion Areas/Questions:
1. What lifesavers did you identify?
2. How do your lifesavers help you?
3. What goals can be developed from completing this activity?

“LIFESAVERS”?  
Who? Where? How?

Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Children (6-11)

Goal of group session: To introduce the children to authority figures in the community and the positive influence they have on the community.

Title of group session: “Authority Figures”

Materials needed: Community transportation

Instructions: Gather the group to discuss the rules and the goals for the treatment session. Go on the community outing and then process the session following the outing.

Activity: The community outing may include police officers, firefighters, doctors, teachers, clergy, elected officials, etc. Encourage the children to think of questions to ask the community members. Discuss ways the children can get involved in the community and to surround themselves with positive influences.

Possible Discussion Areas/Questions:
1. What did you learn from the community outing?
2. How can you surround yourself with positive influences?
3. In what ways can you get involved in the community?
4. What did you most enjoy about the outing?
Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Children (6-11)

Goal of group session: To learn the value of volunteering and to alter the contexts surrounding the children to represent positive influences.

Title of group session: “Value of Volunteering”

Materials needed: Community transportation

Instructions: Gather all the children at the beginning of the session to discuss group rules and goals and at the end of the session to process the experience.

Activity: Take the children to a local facility to demonstrate the importance and value of volunteering. Facilities may include humane society, hospital, shelters, etc. This session may be done a few times during the treatment program. Also encourage the children to volunteer on their own time to demonstrate responsibility and increase their positive influences surrounding them.

Possible Discussion Areas/Questions:
1. What did you most enjoy about the volunteer experience?
2. What did you learn from the experience?
3. How does volunteering help you?
4. How does volunteering help others?
5. How would you encourage friends and family to participate with volunteering?
Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Children (6-11)

Goal of group session: To help the children understand ways to alter their contexts and increase their awareness of positive influences.

Title of group session: “Community Outing”

Materials needed: No materials needed besides transportation

Instructions: Instruct the children to help establish group rules prior to leaving on the community outing. Have each child write down two goals they would like to achieve while on the outing.

Activity: Take a community outing to a local attraction (i.e. zoo, park, museum). While on the outing discuss ways each child’s physical and social environments impact their life.

Possible Discussion Areas/Questions:
1. What does physical environment mean? Give examples.
2. What does social environment mean? Give examples.
3. How do your friends influence you?
4. What can you do to surround yourself with positive influences?
Occupational Therapy Protocol for Adolescents

Ages 12-17
Protocol for the Treatment of Adolescents

1. Referral Form

2. Assessments
   - Adolescent Initial Interview
   - Parent/Caregiver Initial Interview
   - Parent/Caregiver Satisfaction Rating Scale
   - Adolescent Satisfaction Rating Scale
   - Adolescent Role Assessment

3. Suggested Interventions
   - Establish/Restore
   - Prevent
   - Adapt/Modify
   - Create
   - Alter

4. Outcome measures
   - Parent/Caregiver Satisfaction Rating Scale (same as above)
   - Adolescent Satisfaction Rating Scale (same as above)
Occupational Therapy Referral Form

Child/Adolescents Name: ____________________________________________

Date of Birth: ________ Age: ________ Gender: ________

Parent/Caregiver Name: ____________________________________________

Parent/Caregiver Phone Number: ____________________________ (Home)
                                                                  ________________ (Work)

Diagnosis: _______________________________________________________

Current Allergies: _______________________________________________

Current Medications: _____________________________________________

Reason for Referral:
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Referral Source:

☐ Parent
☐ Pediatrician
☐ Primary Care Physician
☐ Psychiatrist
☐ Psychologist
☐ Social Services
☐ Teacher
☐ Other _______________________

_________________________________________________________________

Referring Individual Signature ___________________________ Date ____________
ADOLESCENT INITIAL INTERVIEW

Biographic Information
How old are you? __________ When is your birthday? __________
Where do you live (rural/urban/suburban)? _______
What is the street address? _____________________

Home
Who lives in your house? What are the ages of siblings?
How do you feel you get along with your siblings and parents? Explain.
Do you have any pets?
What chores do you do at home?
Does your mother/father work? What does your mother/father do at work?
What do you do at home that gets you in trouble?
Who gets mad at you when you get in trouble? What do they do?
What does your mother/father do that gets you mad? What do you do?
What holidays/traditions are important to your family? How do you celebrate them?

School
What grade are you in school?
What do you like most about school? What do you like least about school?
Do you ever miss school? If so, why?
How do you feel you are doing in school?
What school activities do you participate in?

Peers
Who are some of your friends? What activities do you like to do with them?
How do you think your friends would describe you?
Is there anyone around your house or at school that you do not like?
Why don’t you like him/her?
Work/Play/Leisure

What do you do after school? What do you do on weekends?

What are your interests?

Do you have a job? If so, where?

Do you get along with co-workers? Why or why not?

Personal Here and Now Status

Why are you here?

Tell me about your experience (How long ago, How long did it last?)

Have you noticed any changes in yourself since the experience?

What do you want to change while you are here?

Tell me something good about yourself.

If you could change anything about yourself by wishing, what would it be?

Length of Interview: __________

Observations

Good/poor eye contact
Cooperative/uncooperative
Appeared comfortable/uncomfortable
Easy/difficult to obtain responses to questions
Direct/rambling responses
Information reliable/unreliable

Additional Comments/Observations

Therapist: ___________________________ Date: ________________

PARENT/CAREGIVER INITIAL INTERVIEW

Biographic Information

How old is your child? __________  When is their birthday? __________

Home

What is your child’s living situation? Do you have any other children?

What chores does your child do at home?

Do you work?  If so, where do you work?  How many hours per week?

How many hours per day do you spend with your child?

What does your child do at home that gets him/her in trouble?

Who does the disciplining of the child?  What kind of discipline do they use?

What holidays/traditions are important to your family?  How do you celebrate them?

School

What grade is your child in school?  How does your child feel about school?

Have you noticed a change in their school performance?

Does your child need help with homework?

Does your child ever miss school?  If so, why?

Has your child been in trouble at school?  If so, what happened?

Does your child participate in school activities?

Peers

Who does your child spend time with?  What activities do they do together?

Do you approve of your child’s friends? Why or why not?

Does your child express concern about other peers?

Work/Play/Leisure

What does your child do after school?  What does your child do on weekends?

What are your child’s interests?

If appropriate, does your child have a job?  If so, where?
How does your child feel about working? Explain.

Have you noticed a change in your child’s interests?

**Personal Here and Now Status**

Tell me about your child’s traumatic experience.

How long ago did your child experience the trauma? How long did the trauma last?

Have you noticed any changes in your child since the trauma?

What do you hope will change in your child from participating in this program?

Length of Interview: ___________

**Observations**

Good/poor eye contact
Cooperative/uncooperative
Appeared comfortable/uncomfortable
Easy/difficult to obtain responses to questions
Direct/rambling responses
Information reliable/unreliable

**Questions/Additional Comments/Observations**

Therapist: ___________________________ Date: ___________________

Adolescent’s Name ___________________ initial _______ date ______

PARENT/CAREGIVER SATISFACTION RATING SCALE

Please circle the number that most clearly reflects your observations.

<table>
<thead>
<tr>
<th>A. Rate your child’s/adolescent’s current performance as a family member.</th>
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<th>B. Rate your satisfaction with your child’s/adolescent’s current performance as a family member.</th>
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<th>C. Rate your child’s/adolescent’s current performance at school.</th>
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<th>D. Rate your satisfaction with your child’s/adolescent’s current performance at school.</th>
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<th>E. Rate your child’s/adolescent’s current performance in peer participation.</th>
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<th>F. Rate your satisfaction with your child’s/adolescent’s current performance in peer participation.</th>
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<th>G. Rate your child’s/adolescent’s current performance in play/leisure activities.</th>
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<th>H. Rate your satisfaction with your child’s/adolescent’s current performance in play/leisure activities.</th>
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<th>I. If applicable, are you aware of any problems with your adolescent at work?</th>
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Comments: __________________________________________________________

______________________________________________________________

______________________________________________________________
ADOLESCENT SATISFACTION RATING SCALE

Week of __________________________

Adolescent’s Name __________________________

1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree

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<tr>
<td>1. I liked group this week.</td>
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<tr>
<td>2. I figured out something about myself in group this week.</td>
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<td>3. I figured out something about my family in group this week.</td>
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<td>4. I learned something about another group member.</td>
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<td>5. I felt comfortable in group.</td>
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<td>6. I shared something about myself in group.</td>
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<td>7. I felt supported by the group leader.</td>
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<td>8. I had fun in group.</td>
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<td>9. I am looking forward to next week’s groups.</td>
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<tr>
<td>10. I talked in group every day this week.</td>
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</table>

A topic I would like the group to discuss is

____________________________________________________________________

Adolescent Role Assessment

The Adolescent Role Assessment (Black, M., 1982) will be administered to adolescents between the ages of 12 and 17 years. The assessment is a semi-structured interview and is divided into six sections of developmental stages. The six sections are childhood play, family, school, peers, adolescent occupational choice, and adulthood work. The Adolescent Role Assessment focuses on the adolescent role changes experienced in the past, present, and future. The results are used in the treatment planning process to help the adolescent transition through the adolescent life stage.

To access the Adolescent Role Assessment, use these references:


Suggested Interventions for Adolescents
Ages 12-17
Establish/Restore
Program Objective: Establish and/or restore skills to cope with the trauma

Intervention Strategy Addressed: Establish/Restore

Age group: Adolescents (12-17)

Goal: To provide the adolescents with different techniques and options to reduce their stress. Coping positively and effectively with stress can be challenging at times and the adolescents need to feel like they can control their own stress.

Title: “Ways to Relieve Stress”

Materials: Pens, paper, and ‘Ways to Relieve Stress’ worksheet (see attached)

Instructions: Divide group members into pairs. Distribute one blank paper and pencil to each sub-group. Give the sub-groups about five minutes to identify all stress management techniques of which they are aware. Discuss importance of topic in relation to specific group needs or issues.

Activity: Distribute the hand-out and have the group compare their ideas to the ideas listed on the sheet. Have each sub-group share their ideas with the groups that were not mentioned on the sheet. This will provide the adolescents with additional techniques for stress management.

Possible Discussion Areas/Questions:
1. What is stress?
2. Why is important to manage our stress?
3. What are some of the unhealthy effects of not managing your stress appropriately?
4. What are the benefits of using the stress management techniques to handle your stress?
5. What techniques have you used before?
6. What techniques do you think are the most helpful?

Ways to Relieve STRESS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity</th>
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<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>blow bubbles</td>
<td>watch a sunrise or sunset</td>
<td>meditate</td>
<td>use visual imagery</td>
</tr>
<tr>
<td>go bowling</td>
<td>do deep breathing exercises</td>
<td>luxuriate in a bath or shower</td>
<td>lie back and watch clouds</td>
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<tr>
<td>take pleasure in quiet time</td>
<td>listen to a relaxation tape</td>
<td>prioritize</td>
<td>reflect on the positives in your life</td>
</tr>
<tr>
<td>read a book</td>
<td>play an instrument</td>
<td>enjoy the weather</td>
<td>enjoy the weather</td>
</tr>
<tr>
<td>fix yourself a cup of hot tea</td>
<td>sing or whistle a song</td>
<td>clean out a closet</td>
<td>attend a free concert</td>
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<tr>
<td>make an edible treat</td>
<td>work on a jigsaw puzzle</td>
<td>play your favorite game</td>
<td>tear up an old newspaper</td>
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<tr>
<td>visit the library</td>
<td>write creatively</td>
<td>roller blade</td>
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<tr>
<td>write a letter to a friend</td>
<td>see a movie</td>
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<tr>
<td>join a support group</td>
<td>draw or paint a picture</td>
<td>have a good laugh</td>
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<tr>
<td>window shop</td>
<td>take a walk in the rain</td>
<td>swim or splash in the water</td>
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<tr>
<td>have fun with a pet</td>
<td>put flowers in your home</td>
<td>delight in your spirituality</td>
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<tr>
<td>go to the park</td>
<td>take a long ride</td>
<td>light a candle</td>
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<tr>
<td>nap for ten minutes</td>
<td>weed a garden</td>
<td>finish something</td>
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<tr>
<td>plan your dream vacation</td>
<td>catch up with a family member</td>
<td>reach out to a support</td>
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<tr>
<td>sit under a shady tree</td>
<td>begin a new hobby or craft</td>
<td>count your blessings</td>
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</tbody>
</table>

Program Objective: Establish and/or restore skills to cope with the trauma

Intervention Strategy Addressed: Establish/Restore

Age group: Adolescents (12-17)

Goal: To help the adolescent boost their self-esteem by identifying their personal attributes as well as have their peers identify attributes for them.

Title: “The Name Game”

Materials: Board, marker, and large sheet of paper for each member

Instructions: Have each person write their name in large letters on the sheet of paper provided (letters vertical). Instruct them that they will have about five minutes to decorate their sheet however they would like.

Activity: Have the person began by writing positive things about themselves that correlate with each letter of their name. Then rotate the sheets of paper around the room and have each group member add to the positives. At the end the individual should get their sheet of paper back filled with positives about themselves. Have each member read some of the positive attributes their peers wrote about them.

Possible Discussion Areas/Questions:
1. How did it make you feel to read all of the positive comments about yourself?
2. Was it hard to write positive comments on your peer’s posters?
3. What is one new thing you learned today about your group members?
4. What is something you learned about yourself today?
5. Did any of the comments from your peers surprise you?
Program Objective: Establish and/or restore skills to cope with the trauma

Intervention Strategy Addressed: Establish/Restore

Age group: Adolescents (12-17)

Goal: To have the adolescents express their thoughts and to encourage them to clarify their own values.

Title: “KISS” (‘Keep It Simple Smartie’)

Materials: Board, marker, candy kisses, ‘KISS’ cut-ups (see attached)

Instructions: Have a discussion prior to the activity about what “KISS” stands for. Then, each member of the group will take a turn in the ‘spotlight seat’ and will read and answer a question from the ‘KISS’ cut-ups.

Activity: Have each member of the group take turns answering a scenario. Make sure to tell the group that each member is entitled to his/her opinion. There is no right or wrong answers. As the member leaves the ‘spotlight’ seat it is recommended that they receive a candy kiss as part of a reward for sharing. To ‘Keep it Simple’ remind the members to answer the question with specifics, stick to the topic, and impose a time limit for each response (3-5 minutes or whatever is appropriate).

Possible Discussion Areas/Questions:
1. What is one new thing you learned today about your group members?
2. What is something you learned about yourself today?
3. How did you feel when sharing with the group?
4. Did you find it harder to sit in the ‘spotlight’ seat to share?

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>1. With whom do I compare myself to and how does it affect me?</td>
<td>2. What does it mean to be a caretaker?</td>
<td>3. Explain: Practice makes perfect.</td>
<td></td>
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<tr>
<td>4. Tell about a healthy relationship in my life.</td>
<td>5. Tell how I overcame a fear of failure.</td>
<td>6. How has fear of abandonment affected me?</td>
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<td>7. What is defeat? (answer must involve concept that defeat is the first step to something better)</td>
<td>8. What is the difference between constructive and destructive criticism?</td>
<td>9. Explain: &quot;There is nothing either good or bad but thinking makes it so.&quot; from HAMLET by William Shakespeare</td>
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<tr>
<td>10. How do I stop being a victim?</td>
<td>11. Can we control our thoughts and feelings? Tell 3 ways to control each.</td>
<td>12. A time I manipulated someone and how I could have been honest and received what I wanted:</td>
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<td>13. What does being moral mean to me?</td>
<td>14. A time I ______ (drank, used, overate, cut on myself) because of anger and what I could have done instead was:</td>
<td>15. Describe 3 of my strengths and 3 weaknesses. How can I better utilize my assets and improve my limitations?</td>
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<td>16. Are people without formal education dumb? Why or why not?</td>
<td>17. What is a 'self-fulfilling prophecy'? Tell a time I measured up to my expectations. Tell a time I expected, then experienced failure.</td>
<td>18. Does money buy happiness? Why or why not?</td>
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</table>

**Program Objective:** Establish and/or restore skills to cope with the trauma

**Intervention Strategy Addressed:** Establish/Restore

**Age group:** Adolescents (12-17)

**Goal:** To increase the level of trust in the adolescents as well as to realize the importance of trust within the group.

**Title:** “Trust walk”

**Materials:** Blindfold for each assigned group

**Instructions:** Group members should do this activity in pairs. The group should begin with a general discussion of trust.

**Activity:** The trust walk will begin with one group member being blindfolded and led and then they will switch roles to give them both the experience. The activity may be outdoors or indoors and it is recommended that this be done in a fairly large area. The “sighted” partner leads the “blind” one around the room and makes sure to encourage their partner to feel for objects such as a chair, bush, vending machine, and so on, whatever the environment provides.

**Possible Discussion Areas/Questions:**
1. What is Trust?
2. Is it good or bad to be trusting?
3. When is it bad to be trusting?
4. When is it good to be trusting?
5. What was it like for you to be blindfolded?
6. What did you learn?
7. Which did you like better- leading or being led?

Prevent
Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Adolescents (12-17)

Goal: To help the adolescent’s move forward despite adversity.

Title: “Get Unstuck”

Materials: Board, marker, masking tape, paper, pencils, crayons

Instructions: Introduce the activity by having a volunteer walk into the group with a piece of masking tape stuck to the bottom of their shoe. Show it to the group and ask, “What will happen when s/he tries to walk?” then “What does it mean to be stuck in one spot?” Elicit that past trauma, regrets, future fears, and untreated emotional abuse can immobilize us.

Activity: Begin the activity by writing the words ‘Get Unstuck’ on board. Have each group member identify a situation or issue they ‘can’t get past.’ Then have each member write a keyword on a piece of tape and instruct them to put it on their shoes. Examples of words: fear, depression, anger, guilt, past abuse, etc. After identifying their keywords have each member draw, write, or think about ways to get ‘unstuck’ and have them share with the group. Symbolize getting ‘unstuck’ by removing tape from shoes and throwing it away.

Possible Discussion Areas/Questions:
1. What can you continue to do in your everyday lives to stay ‘unstuck?’
2. How can others help you become ‘unstuck?’
3. What is one new thing you learned today about your group members?
4. What is something you learned about yourself today?

Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Adolescents (12-17)

Goal: To increase the adolescent's awareness of what they value. This activity will strive to help the adolescent find a balance within their everyday lives.

Title: “This is your life”

Materials: Board, marker, paper, pencils, crayons, ‘This is your Life’ worksheet (see attached)

Instructions: Have a discussion about how each group member can reach their maximum potential in each of the eight areas (family, social, physical, spiritual, vocational, emotional, intellectual, and financial)

Activity: Have the individuals draw themselves doing things necessary for their growth in each area. Then have them share their drawings with the group. Finally, give each member of the group a hand-out with the circle on it and instruct them to divide the circle into the eight categories BUT size of the sections must show amount of attention and effort they put into each area. Then have the group analyze each other’s circle and find the areas that are over-emphasized and also the ones that are being ignored.

Possible Discussion Areas/Questions:
1. What are some ways you can achieve a better balance in your life?
2. What is one new thing you learned today about your group members?
3. What is something you learned about yourself today?
4. Were you surprised with your results?

Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Adolescents (12-17)

Goal: To increase the adolescent’s awareness of different coping skills they can utilize when in a stressful situation.

Title: “Coping Skills Alphabet”

Materials: Board, marker, and ‘Coping Skills Alphabet’ worksheet for each member (see attached)

Instructions: Have each member fill out their worksheet independently filling in a coping skill for each letter of the alphabet

Activity: Have a volunteer print the letters of the alphabet on the board. Then have the group members take turns selecting a letter and write a coping skill under that letter and share why it is an important coping skill to use. After answering questions or receiving suggestions from peers each individual will then select the next person to write on the board. Continue with this process until all of the letters have a suggested coping skill.

Possible Discussion Areas/Questions:
1. What are coping skills?
2. Why is it important to use coping skills in our everyday lives?
3. When have you needed to use coping skills in your life?
4. What is one new coping skill that you learned today that you want to try?

# COPING SKILLS ALPHABET

**WORKSHEET**

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Program Objective: Prevent further psychological and/or emotional problems

Intervention Strategy Addressed: Prevent

Age group: Adolescents (12-17)

Goal: To increase the adolescents awareness of problems and help them to effectively learn how to problem solve through the problem. Also it allows the adolescent to identify opportunities and recognize the advantages of new challenges.

Title: “Fork in the Road”

Materials: Board, marker, pencils, and ‘Fork in the Road’ worksheet (see attached)

Instructions: The session should begin by having a discussion regarding “what does it mean to face a fork in the road?” Also discuss deciding between two choices.

Activity: Give each member the ‘Road not taken’ worksheet and have the group read the poem in unison a few times and discuss member’s interpretations. Then give the member’s time to fill-out the worksheet. They may fill-out the worksheets alone or else break into groups of two and ask each other the questions. Once all members have finished the worksheet have them share a few of their responses with the group.

Possible Discussion Areas/Questions:
1. Was this a challenging worksheet to fill-out? Why or Why not?
2. How many of you have problems with decision making? Are there issues that are harder than others?
3. What did you learn about yourself? What did you learn about your fellow group members?

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;
Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,
And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.
I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.

by Robert Frost

1. When did you face two choices?
   __________________________________________________________

2. Which did you choose and why?
   __________________________________________________________

3. What was the outcome?
   __________________________________________________________

4. What does it mean to take the "road less traveled by"?
   __________________________________________________________

5. When did you take an unfamiliar "road"?
   __________________________________________________________

6. What were the results?
   __________________________________________________________

7. Give three examples of unfamiliar "roads" you might take soon. These may involve healthy risks, unpopular decisions, resisting peer pressure and accepting new challenges.
   __________________________________________________________

8. How might each choice you noted in #7 "make all the difference"?
   __________________________________________________________

9. When is it advisable to take a "well traveled road"?
   __________________________________________________________

10. Describe a "tried and true" path you are (or need to be) following and its benefits. This may involve your recovery program, doctor's/therapist's recommendations, using coping skills.
    __________________________________________________________

Adapt/Modify
Program Objective: Adapt and/or modify the context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Adolescents (12-17)

Goal: To evaluate qualities and values of friends and friendships. To help the adolescents become aware of and change negative friendships.

Title: “Let’s Pretend - a Friend”

Materials: Board, marker, pens, and ‘Let’s pretend-a friend’ worksheet (see attached)

Instructions: Discuss the importance of having friends that are positive influences and have the same values as you. Hand out the worksheet and have the group members fill it out according to what they feel a friend should be like.

Activity: Have each member share their qualities with the group. Compile a list and record it on the board for the members to refer to. Have the members evaluate their current friendships and identify what action needs to be taken to make all of their friendships positive. Encourage them to take action in order to eliminate the performance barriers in their life.

Possible Discussion Areas/Questions:
1. What is meant by a friendship?
2. Discuss roles of friendships in people’s lives.
3. What are some of your values regarding friendships?
4. What are some actions you can take to guarantee you have positive influences?

# Let's pretend - a friend

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<tr>
<th>Male □ / Female □</th>
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<tbody>
<tr>
<td>Approximate age</td>
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<td>Physical Appearance</td>
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</table>

<table>
<thead>
<tr>
<th>Personality / Beliefs / Values</th>
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<tr>
<td>Other Special Talents / Interests / Abilities</td>
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</table>

<table>
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<tr>
<th>What would he / she offer you?</th>
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<tr>
<td>What would you need from him / her?</td>
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<td>What would you offer him / her?</td>
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<table>
<thead>
<tr>
<th>Have you ever had anyone like this in your life?</th>
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<tbody>
<tr>
<td>Who?</td>
</tr>
<tr>
<td>Is there anyone in your life that could be this person?</td>
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<tr>
<td>Who?</td>
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<tr>
<td>If no, how could you go about finding this friend?</td>
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Program Objective: Adapt and/or modify the context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Adolescents (12-17)

Goal: To increase the adolescent’s awareness of their roles. The group will help them become aware of areas needing improvements within these roles as well as give them suggestions for improvement.

Title: “Roles”

Materials: pens and ‘Roles’ worksheet (see attached)

Instructions: Introduce the group to examples of roles such as sister/brother, father/mother, worker/student, friend, etc. Give each member a copy of the ‘roles’ worksheet. Encourage group members to complete the handout and then turn them into the facilitator.

Activity: Collect each member’s worksheet and then read from the worksheet and encourage others to guess the author. Award points for each guess that is correct and have the author talk about their role and what they plan to do to improve performance and satisfaction within that role.

Possible Discussion Areas/Questions:
1. What is a role?
2. Identify your feelings within each role.
3. What are things you do well within your role?
4. What are things you need to improve within your role?

My roles:

1. __________________ 
2. __________________ 
3. __________________ 
4. __________________ 
5. __________________ 

Choose one role: __________________ 

<table>
<thead>
<tr>
<th>Things I do well within this role.</th>
<th>Things I don't do well within this role.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOCUS ON POSITIVES!</strong></td>
<td><strong>ROOM FOR CHANGE!</strong></td>
</tr>
<tr>
<td>1.</td>
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Program Objective: Adapt and/or modify the context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Adolescents (12-17)

Goal of group session: To improve the parent-adolescent interaction by engaging them together in pleasurable, successful activity.

Title of group session: “Parent-adolescent activity group”

Materials needed: A variety of activities available for the adolescents and parents to chose.

Instructions: Report the goals of the group to the adolescent and the parents. Instruct each parent-adolescent group to choose an activity together to work on with the goal of completing in one group session.

Activity: Parent-adolescent activity group

Possible Discussion Areas/Question
1. What did you like about working on this activity? Why?
2. What did you not like about working on this activity? Why?
3. How did you feel when working on the activity? Why?

Program Objective: Adapt and/or modify the context or tasks to reduce performance barriers

Intervention Strategy Addressed: Adapt/Modify

Age group: Adolescents (12-17)

Goal: To address concerns that the adolescents may have regarding therapy sessions. To adapt and/or modify the therapy environment so that the adolescents will feel comfortable sharing their thoughts and concerns.

Title: “All about us”

Materials: Pen and Paper for each member of the group

Instructions: Ask each group member to think of at least two rules that they think are important to follow when attending group.

Activity: Ask each member to share their rules with the group and then compile their list together and write the rules on a poster. Hang the poster on the wall as a reminder for the group members to follow the rules. After establishing the rules, then ask the group members to share what their expectations are from attending therapy. In addition ask them to share their learning style with the group and different strategies that will make them feel comfortable sharing with the group. Encourage the group members to be respective of each other during group and to remember what makes their other group members feel comfortable.

Possible Discussion Areas/Questions:
1. Why are rules important?
2. What do you think are some fair consequences for breaking the rules?
3. What other things would you like to talk about today?
4. What makes you feel uncomfortable when sharing with the group?
5. Why do you think I asked each one of you to identify some rules?
Create
Program Objective: Create a safe environment that promotes trust and open communication

Intervention Strategy Addressed: Create

Age group: Adolescents (12-17)

Goal: To increase the awareness of trauma within the community. To help the adolescents feel safe and accepted within the community.

Title: “Community presentation”

Materials: Hand-outs for the audience on trauma

Activity: Give a presentation to the community on the effects of trauma and the importance of having support from the community. If the adolescents are willing have them assist in making the pamphlets and/or giving the presentation. The presentation could be done at the school to educate classmates of the adolescents on how they can be positive role models to each other and encourage their growth.

Possible Discussion Areas/Questions:
1. What is trauma?
2. What are some signs and symptoms of trauma?
3. How can you help people who are experiencing trauma?
4. Discuss the overall impact of a traumatic event on the growth of the individual.
Program Objective: Create a safe environment that promotes trust and open communication

Intervention Strategy Addressed: Create

Age group: Adolescents (12-17)

Goal: To have the adolescent’s help children as part of a mentorship program. This will help the adolescents enjoy themselves while helping children.

Title: “Mentorship Program”

Materials: Books, games, and other chosen activities

Activity: Set-up a location either at the local preschool or elementary school for a mentorship program. Have the adolescent’s be part of a mentorship program where they are assisting children with reading, writing, or simply playing with them.

Possible Discussion Areas/Questions:
  1. What did you enjoy about this activity?
  2. What were the challenges along with being a mentor?
  3. What did you learn about yourself today?
  4. Were you aware of a mentorship program before?
**Program Objective:** Create a safe environment that promotes trust and open communication

**Intervention Strategy Addressed:** Create

**Age group:** Adolescents (12-17)

**Goal:** To have the adolescent’s volunteer at a local nursing home and facilitate a game of BINGO. This will allow them to interact with the elderly in a fun game of BINGO.

**Title:** “BINGO”

**Materials:** Prizes for BINGO

**Activity:** Set-up a date for the adolescent’s to facilitate BINGO at a local nursing home. Have the adolescent’s call the BINGO game, give out prizes, and assist the elderly as needed i.e. helping them read the cards, repeating numbers, and transporting to and from the BINGO room

**Possible Discussion Areas/Questions:**
1. What did you enjoy about this activity?
2. What were the challenges of facilitating the BINGO game?
3. What did you learn about yourself today?
4. What did you learn about helping the elderly?
Program Objective: Create a safe environment that promotes trust and open communication

Intervention Strategy Addressed: Create

Age group: Adolescents (12-17)

Goal: To have the adolescent’s organize and host a community gathering. The adolescents will be responsible for planning and advertising for the party

Title: “Community Gathering to Promote Trauma Awareness”

Materials: Food, games, posters

Activity: Set-up a date for the adolescent’s to host a community wide party. Have the adolescents plan the party including what kind of food, games, and other entertainment they want at the party. Also have the adolescents arrange for a guest speaker that can inform the community about trauma and the impacts of trauma.

Possible Discussion Areas/Questions:
1. What did you enjoy about this activity?
2. What were the challenges of planning a large event?
3. What did you learn about yourself today?
4. What did you learn about the community?
Alter
Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Adolescents (12-17)

Goal: To introduce the adolescents to different volunteer possibilities within the community. To increase their awareness of how they can help others and in turn feel good about themselves.

Title: “Volunteer exploration”

Materials: No materials needed. Arrange for a speaker on different volunteer opportunities and then take a fieldtrip to a specific site for the adolescents to volunteer at.

Activity: Have a speaker introduce the different volunteer opportunities available for the adolescents to participate in. As a group decide on a site that they would like to visit and spend a few hours volunteering. Encourage the group members to follow-up with a site of interest and pursue a volunteering position there.

Possible Discussion Areas/Questions:
1. Why do people volunteer?
2. How do you feel after helping someone?
3. What are some benefits of volunteering?
4. Discuss different volunteering opportunities.
5. What can you learn about yourself from volunteering?
Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Adolescents (12-17)

Goal: To have the adolescents reflect on all the influential people in their life whether positive or negative. To show them that they have a lot of positive people in their life that truly cares about them. Also to help them realize that it is not good for them to spend time with people who are a bad influence.

Title: “Influential people who have made an ‘imprint’ on my life”

Materials: Pens and ‘Influential people’ worksheet (see attached)

Instructions: Begin the group with a discussion on the importance of having positive people in their lives. Provide the group members with examples of how to complete the worksheet.

Activity: Encourage group members to complete the worksheet. Tell them to look at the positive and/or negative influences people have had on their lives. End the group with a discussion and have each group member share some of their examples of influential people.

Possible Discussion Areas/Questions:
1. What were you feeling while completing this worksheet?
2. Did you find that you had more positive or negative influences in your life?
3. How can you cope with the negative influences?
4. What is one new thing you learned about yourself today?
5. What is one new thing you learned today about your group members?

Influential people who have made an *imprint* on my life!

<table>
<thead>
<tr>
<th>Influential people in my life</th>
<th>What about them influenced/influences me?</th>
<th>How did/or does that influence my behavior?</th>
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<tbody>
<tr>
<td>FAMILY MEMBERS</td>
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<td>FRIENDS</td>
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<td>TEACHERS</td>
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<td>PUBLIC FIGURES (ANIMAL CLERGY)</td>
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<td>LOYAL HEROS (PEOPLE IN HISTORY)</td>
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<tr>
<td>OTHER</td>
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</tr>
</tbody>
</table>

Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Adolescents (12-17)

Goal: To introduce the adolescents to some positive forms of leisure activities they can participate in. To help them become aware of some of the possibilities within their community.

Title: “Just for fun”

Materials: Transportation to local YMCA or gym

Activity: Contact the local YMCA or gym to set-up a time for the group to go on a tour and explore some of the opportunities available there. Help them to find details on different classes or leisure activities they would like to join. Upon completion of the tour give the group an opportunity to play a group game or something else of their choice.

Possible Discussion Areas/Questions:
1. What is leisure?
2. Why is important to include leisure activities in your life?
3. Were you aware of all the different leisure activities available?
4. Have you ever been involved in these types of groups offered at the YMCA?
Program Objective: Alter contexts to represent positive influences

Intervention Strategy Addressed: Alter

Age group: Adolescents (12-17)

Goal: To introduce the adolescents to authority figures so they feel comfortable and aware of their job duties. To integrate the adolescents into the community and promote community awareness.

Title: “Community Experience”

Materials: No materials needed just a form of transportation

Activity: Contact the local police department and set-up a time for the group to go for a tour. During the tour it would be beneficial for the officers to talk to the group about what their job duties are. Encourage the group members to ask questions of the police officers.

Possible Discussion Areas/Questions:
1. What is something new you learned today?
2. Have your attitudes towards the police changed at all? Why or Why not?
3. Did you feel comfortable asking questions?
4. How did you feel going into the jail?
REFERENCES


CHAPTER FIVE

SUMMARY

The purpose of this project was to explore the literature on trauma in children and adolescents and ultimately develop an occupational therapy program for children and adolescents exposed to trauma. The significant findings from the literature review include the impact of trauma, established treatment strategies, and occupational therapy treatment programs. The impact of trauma was shown to affect the psychological/emotional, behavioral, developmental, and familial aspects of the child or adolescent. Children and adolescents may begin to blame themselves for the traumatic event they experienced. In addition, traumatic events not only affect the individual but also the dynamics in the family. Parents may become distressed by their child’s change in behavior and may respond differently to the child. The literature indicated that treatment for children and adolescents exposed to trauma commonly include cognitive-behavioral therapy, behavioral therapy, and parental education/training. Two occupational therapy treatment programs were found specific to children and adolescents exposed to trauma. Both programs identified the importance of the child and/or adolescent’s context, specifically related to family and community involvement. Context was determined to either serve as a support for the child or adolescent or a barrier to their occupational performance.

The information gained from the literature review was used as a guide to develop the product, "An Occupational Therapy Program for Children and Adolescents"
Exposed to Trauma.” Included in the product is a program description, program objectives, suggested assessments, and a protocol for both children and adolescents to be used by an occupational therapist during treatment.

Limitations of the project

A limitation of this project was that the occupational therapy program developed for children and adolescents exposed to trauma did not address the importance and necessity of having an interdisciplinary team for the treatment of this population. Other important team members such as psychologist, psychiatrist, social work, nursing, teachers, school counselors, and the family need to be considered. The role of each of these team members was not described in this project. Another limitation of this project is that the proposed program has not been implemented and therefore the effectiveness has not been tested.

Proposal for implementation

The occupational therapy program that was developed for the treatment of children and adolescents exposed to trauma is made available to interested parties upon request. Inservices can be conducted to present the developed program to facilities who serve children and adolescents exposed to trauma. The proposed program is designed to be implemented in a day treatment or outpatient treatment setting where children and adolescents exposed to trauma may be receive treatment. These settings will allow for increased participation with the contexts surrounding the children and adolescents.

Conclusions

The literature review indicated the need for further occupational therapy treatment programs as well as research on children and adolescents exposed to trauma. The
program that was developed provides guidelines for therapists working with children and adolescents exposed to trauma. The developed program presents the occupational therapy treatment process using the Ecological Model of Human Performance to guide practice with children and adolescents exposed to trauma.

Recommendations

Further occupational therapy research on the impact of trauma on the occupational performance of children and adolescents will help occupational therapy practitioners better understand the unique needs of this population. Outcome measure data needs to be gathered and analyzed by established occupational therapy programs serving children and adolescents exposed to trauma to demonstrate the effectiveness of occupational therapy services with this population.
APPENDIX

Diagnostic criteria for
309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2) The person's response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
   3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
   4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2) Efforts to avoid activities, places, or people that arouse recollections of the trauma
   3) Inability to recall an important aspect of the trauma
   4) Markedly diminished interest or participation in significant activities
   5) Feeling of detachment or estrangement from others
   6) Restricted range of affect (e.g., unable to have loving feelings)
   7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) Difficulty falling or staying asleep
2) Irritability or outburst of anger
3) Difficulty concentrating
4) Hypervigilance
5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

**Acute:** if duration of symptoms is less than 3 months

**Chronic:** if duration of symptoms is 3 months or more

Specify if:

**With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

References


