

Providing practical, clinical information to families and children's professionals.

# H

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## MAGAZINE

2011 Vol. 16, No. 1

### **Special Focus: Family Centered Treatment**

- Family Centered Therapy
- Setting the Course
- Family Involvement

### **Plus:**

- KidsPeace and the Sanctuary<sup>®</sup> Model
- EQ: The Other Intelligence
- The Ambiguous Foster Child  
and more ...



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Promoting Educational Excellence in Children's Behavioral Health Care



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Healing Magazine is a publication of: KidsPeace c/o Creative Services Department 4085 Independence Drive Schnecksville, PA 18078-2574

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If you are a professional in the field of mental health, education or parenting, we welcome your submission. Healing articles should be 200 to 1,200 words in length and consist of practical, clinical information about children's mental health that can be applied in the home, classroom, community and/or office setting.

Microsoft Word-compatible documents on CD should be directed to: **Healing, c/o KidsPeace, 4085 Independence Drive, Schnecksville, PA 18078-2574**

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Will Isemann, KidsPeace President and CEO

## Dear Friends of KidsPeace,

In this issue of *Healing*® Magazine, we focus on Family Centered Treatment (FCT) and how this approach differs from other models of care. Therapists understand that children do not exist in vacuums while their emotional, behavioral or psychological issues develop. KidsPeace works with families to teach ways to nurture and support the child, contributing to greater success and healing.

The entire family participates in treatment to address and resolve issues, and this approach benefits all family members. An excellent example of successful FCT is our KidsPeace New England Residential Autism Program, where autistic children and teens reside in our campus facility but are visited, in many cases, several times a day by their parents, who participate in their children's treatment and learn skills to use at home.

This issue also features articles that target misconceptions about school-related homicides, as well as a discussion about Emotional and Social Intelligence and its impact on children's success by our regular contributor Ellen Notbohm. Dr. Susan Cornbluth writes about "The Ambiguous Foster Child," who has unresolved issues of loss.

There is also an informative article that describes how the Sanctuary® Model may be used to address traumatic events to help families and children heal. We are currently implementing the Sanctuary Model at KidsPeace to create an environment of safety, empowerment and positive change for our children, their families and our own associates.

We welcome your input on our magazine, and we encourage authors to submit articles for future issues. We also invite you to visit our websites for news, information, assistance and useful tips.

- KidsPeace.org is our primary website
- Fostercare.com is focused on the foster care services we offer throughout the country.
- HealingMagazine.org provides online copies of current and past issues of this magazine.
- TeenCentral.Net is a free, anonymous website that helps teens with issues and problems they face
- ParentCentral.Net offers advice and information to parents who need an anonymous site to ask questions and know that they are not alone.

Thank you for subscribing to *Healing Magazine*, and have a wonderful summer.

Will Isemann



# KidsPeace®

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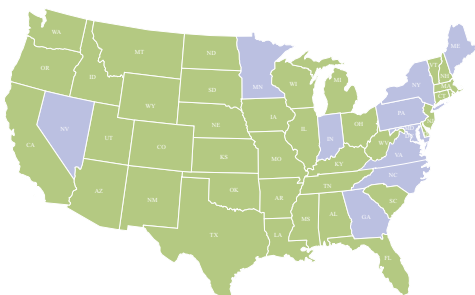
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# KidsPeace and the Sanctuary® Model: Helping Families Find Peace

by Leslie Tenbroeck, LCSW

*Raheem Khawaja\* was a troubled boy who came to KidsPeace in the fall of 2009. Raheem's family had emigrated from Pakistan shortly after his birth; he had no conscious memories of living in Pakistan and was grounded in American culture... skateboarding, cartoons and McDonald's. Raheem had done very well at his local elementary school, which was located within walking distance from his new home. His father walked him to school in the morning, and his mother was waiting at home for him when he returned afterwards. Raheem did well academically and had many friends. It seemed like middle school would be a smooth transition. However, problems started almost immediately in the fall of his sixth grade year. Raheem was suspended twice for fighting on the bus. His grades dropped, and he became moody and unhappy. His parents grew concerned. What was wrong with their son? When they asked him, he had no answers. His pediatrician assured them that the onset of puberty often produced such changes in behavior... this reassured them, for a time. Then, following another bus incident, Raheem was suspended for bringing a knife to school. The guidance counselor insisted that the parents take their son to the emergency room to obtain a psychiatric evaluation. It was then that Raheem was admitted to the KidsPeace Hospital for treatment.*

*Raheem was pleasant and cooperative during his stay. He followed the rules and did not exhibit any behavior problems. The Treatment Team had a difficult time understanding why this cheerful boy was having such a difficult time at school. The therapist gathered a comprehensive history of Raheem's experiences, and everything she was told appeared to support the story of a developmentally normal, healthy boy. Then she asked Raheem's parents about their own lives. Suddenly, the*

*picture began to change. Mr. Khawaja's face grew troubled; his wife looked down at her hands entwined in her lap. In halting English, Mr. Khawaja began to talk about living in Pakistan during war. "We lost our home," he explained, "As many did. Raheem was born in the basement of a building that had been bombed. There was nowhere safe to go, and my wife couldn't travel in her condition. The neighbors helped us." The clinician asked gently, "Did you lose many people who you cared about?" Mrs. Khawaja began to cry. Her husband merely responded, "It was very bad. Ever since we were young. We came here and were very happy to be in the United States."*

*As the days went on, the clinician worked closely with the Khawaja family, and significant issues emerged. Living in a war zone where they feared for their lives, and the lives of their loved ones, every day had emotionally traumatized Raheem's parents. Their experiences of terror, loss and catastrophe had shaped the way they responded to the world. They thought that all of these problems would disappear when they came to America, and what they found was that the fear and panic that they'd learned to live with came to America with them. Raheem's parents lived every day in fear and he, living with them, did as well.*

The events that this family experienced create a tragically familiar story to many of the professionals who work in mental health treatment. A traumatic event is defined as a single experience, or an enduring series of events, that completely overwhelm the individual's ability to cope<sup>1</sup>. Traumatic events include some of the experiences that we least like to think about: Violent crime, natural disasters, accidents, wars, community violence, child physical and sexual abuse, bullying and domestic violence. While there are many different situations that can be



considered traumatic, these events have one thing in common: They are events that cause overwhelming feelings of fear, helplessness and/or horror.<sup>2</sup> Think of the victims of concentration camps; the earthquake survivors in Japan; Viet Nam veterans.

We are only beginning to understand the role that traumatic events play in the development of mental health problems, substance abuse and disruptive and dangerous behaviors. Severe and chronic trauma may lead to physical changes inside the brain and to the brain's chemistry, which damage the person's ability to adequately cope with stress. This is particularly problematic for children. Children who have witnessed or have been victims of interpersonal and community violence, have been neglected or have suffered terrible losses often present with a wide range of emotional and behavioral problems<sup>3</sup>.

Children, like Raheem, can also suffer from secondary or "vicarious" trauma. This form of traumatization impacts people who are in a close relationship with traumatized individuals. Raheem's parents' experience of terror and loss had resulted in changes in their entire approach to life. Mrs. Khawaja in particular was afraid to leave the house. Moreover, she was terrified to let her child out of her sight and would panic when she put him on the bus in the morning. Mr. Khawaja was working two

jobs and feared that he could at any time lose his jobs, and his family would again be homeless. Raheem told the clinician that he wished he didn't have to go to school; he believed that he was safer at home, with his parents, and that they needed his help.

What is significant about Raheem's situation is that the clinician asked this family about their history of trauma. In many cases, such information is overlooked as frustrated parents, overworked professionals and harried teachers focus on more immediate approaches to behavior. Often, the child is punished by suspensions or expulsions; various medications are tried without a thorough understanding of the problem; or the behavior is minimized or ignored until it becomes a significant threat to the safety of the community.

At KidsPeace, we recognize the role of trauma in the lives of the children and families who come to us for help, and we treat the entire family. The Sanctuary® Model, which is being implemented as the model of care at KidsPeace, provides the tools and the theory to help us to create a culture of safety, empowerment and positive change. This model teaches that, in order to recover from trauma, people need to live in a community of supportive people who are committed to their growth and healing. While KidsPeace strives to provide that for our children, we recognize that the best place

for a troubled child to heal is in a safe, supportive family; and the best place for a troubled family to heal is within a safe, supportive community. KidsPeace is committed to using the Sanctuary Model, its theories and its tools to help our community become one where children and families, like the Khawajas, find peace. ◀

For more information on the Sanctuary Model, visit the site <http://www.sanctuaryweb.com> or contact the author at 800-25PEACE.

<sup>1</sup>Van Der Kolk, B.; McFarlane, A.; Weisaeth, L., Eds. (1996). *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: Guilford Press.

<sup>2</sup>Bloom, S. L. (1997) *Creating Sanctuary: Toward the Evolution of Sane Societies*. (1997). New York: Routledge.

<sup>3</sup>Farragher, B. and Yanosy, S. (2005). *Creating A Trauma-Sensitive Culture In Residential Treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 97-113.



*Leslie Tenbroeck, LCSW, Sanctuary® Coordinator and Clinical Instructor at KidsPeace, has over 20 years experience working in the mental health field with a broad range of direct-care experience with children and families. Ms. Tenbroeck has extensive experience in crisis management; she has taught courses in Handle with Care and Professional Crisis Management and is currently a certified instructor for Life Space Crisis Intervention. She has taught courses in conjunction with the American Health Institute, the Penn State Cooperative Extension and Norwich University. She is affiliated with the Sanctuary Institute and is an advocate for trauma-informed care. For the past nine years, she has been teaching and assisting in developing curriculum for direct care staff in multiple areas of instruction related to children's developmental and behavioral health, including the treatment of self-injurious behavior, therapeutic relationships, group therapy and trauma treatment. She is currently the designated coordinator for the implementation of the Sanctuary Model at KidsPeace. Ms. Tenbroeck lives in Allentown, PA, with her husband and two sons.*



# the GREAT DISCLOSURE DEBATE

By Tracy E. Hill, Ph.D.

Counselor self-disclosure may be defined as the practice of revealing personal information about oneself to a client. Few research articles have addressed this topic, debating the pros or cons of self-disclosure. However, self-disclosure is a serious consideration from a professional viewpoint for psychotherapists, counselors and psychologists.

There are three main types of self-disclosure (Anderson & Anderson, 1989).

## Professional Disclosure

Professional disclosure is revealing your professional experience and education. Professional disclosure is something most of us reveal by virtue of the acronyms following our names (e.g., Ph.D., LPC, M.S., etc.). We also disclose to clients through the diplomas and certificates hanging on our walls. Most of us do this basic inquiry when we walk into a professional's office and scan the walls of diplomas. Our professional experience is also requested by savvy clients who want to be assured that we have the proper experience and training before trusting us with their emotional and mental well-being. Similarly, we often ask our lawyer or medical doctors, "How many cases like this have you won/cured?" In our profession, the question may be in the form of, "Do you work with adolescents/depression/anxiety (fill in the blank)?" As professionals, we provide counseling and psychological services for specific mental health concerns or subgroups of individuals (adolescents, LGBT, etc.) with proper training and certifications. Clients come to us for professional,

unbiased, nonjudgmental services, and they want assurances that we have the experience and qualifications necessary to help them. Professional self-disclosure is expected and warranted for counselors and therapists. It is the other two types of disclosure that often land counselors in murky water.

thinking that, by sharing her personal histories, she is helping the client. Yet, unlike other professionals, if we disclose our personal information, it may put us at a disadvantage to helping our clients.

Dies (1973) and Strong (1968) demonstrated that conveying our weaknesses to clients undermines our

role as experts. Does it matter if your divorce attorney is married or not? Would you care if your anesthesiologist or chiropractor had been under anesthesia or had back problems of his own? Or what if your accountant shared that he had been sober for the past several years? Would it change his expertise in finances? The personal disclosure of professionals does not impact their treatment or your care. However, a counselor's personal disclosure may impact the client's

## Personal Disclosure

Personal disclosure is revealing more private and individualized personal information about oneself to a client. Our personal disclosure is often displayed in our offices through photographs of family and friends, vacation homes or the scenic trips we took. Personal self-disclosure is also revealed by the jewelry we wear (e.g., wedding band, necklaces and bracelets with disclosing charms and pendants) or the holiday office decorations we choose (e.g., religious, political). Other times, counselors self disclose private information to clients through their personal history. Personal stories of a counselor's divorce, depression or bouts with bulimia may lure a counselor into

perception of your knowledge, bias or impartiality. For example, sharing your own relationship problems, anxiety or addictions may undermine your ability to remain professional or knowledgeable from a client's viewpoint. A client may feel, "Well, if she could not maintain a marriage (sobriety, etc.), how can she help me?" More importantly, what concern is your personal life to them?

Every week, I am asked personal questions by my patients - from the mundane to the bigger issues. What does the E in my middle name stand for? Am I married? Am I divorced? Have I ever gone through depression? The questions are endless. My answer is always the same. It is not about me; we are here to talk about you. My office photos and décor reveal nothing of my personal history. My jewelry is kept minimal and



non-descriptive. When a client persists, I often turn the question around and ask “Why is this so important for you to know?” Most often clients are redirected with this response, and we continue with our counseling session. Sometimes, a client will say “Well, if you were \_\_\_\_\_, then you would understand me better.” I always respond, “A divorce lawyer does not need to be divorced to win your case; nor does the best criminal attorney need to have committed a crime in order to help you.” So far, I have yet to lose a client over my lack of self-disclosure, and my clients respect my professionalism and focus on their concerns.

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## Affective Disclosure

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Affective disclosure can be defined as when a counselor reveals his beliefs, views or feelings on client-related issues. This is often another mistake that professional therapists make. Self disclosing our beliefs or views on client related matters does not let us maintain our impartiality – which is why our clients come to see us. If a client wants to know whether or not we agree, disagree, believe in or do not agree with their decisions, choices or views on particular concerns – then she may as well seek the advice of her friends or family.

As professional counselors, we do not advise clients. Unfortunately, counselors often provide their opinions to a client’s problem. This can bias a counselor’s judgment and objectivity in providing the client a sounding board for them to process through their own predicaments utilizing their own belief systems rather than incorporating ours.

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## The Patient’s Point of View

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In 2003, (Kim, Hill, Gelso, et. al) a study on the effect of self-disclosure on East Asian American clients concluded that affective disclosure was not as helpful (effective) for clients as disclosing strategies (e.g., “When I get anxious, I use breathing techniques”). However, as a counselor, I still believe that best practice would utilize any strategy that

takes the personal self-disclosure out of the equation and replaces it with a generic ‘client’ (e.g., “Some clients use a breathing technique when they start to feel anxious”). Clients do not seek the help of a therapist for the sake of knowing the therapist’s views or beliefs. Clients come to your office with their own set of values and beliefs already in place. It is your job to help them either accommodate those beliefs into their particular situation or adapt those views so they reconcile cognitive discord or distortions.

did not hear or understand them. In one particular session, I recall my ‘client’ sat in the office with tears streaming down his face. The counselor ignored the tears and shared her story about her own son’s situation. This specific client and situation were repeated with two other counselors with a nearly identical outcome. The misconception by therapists is that by self disclosing to our clients, we will help them form a trust or bond with us. However, at the root of all therapy is relationship building. As Carl Rogers taught us, we build rapport and

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*If we disclose our personal information, it may put us at a disadvantage to helping our clients.*

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My clients fill out an intake form that asks an open-ended question (if they have had previous counseling) “what worked or didn’t work?” One of the most frequent answers I get is, “He/she talked too much about her/himself.” Over the past several years, I have participated in several ‘mystery’ counseling sessions; whereby I was asked to take a ‘client’ and evaluate the effectiveness or appropriateness of different counselors. I bring along an identified patient (e.g., child). In nearly 100% of the sessions I have attended, the feedback I get from the identified patient is that the counselor talked too much about himself in the attempt to share and perhaps show similarities in the situation. The patients overwhelmingly felt that the counselor

trust with our clients through empathy, positive regard, immediacy, congruence, respect and concreteness. I think if Carl Rogers were around today, he would agree to keep the self-disclosure to a professional and limited level.

Professional self-disclosure is a valuable tool in establishing the core conditions for a positive, helping relationship with a client. Personal and affective disclosures are unprofessional and unwarranted in the role of the professional counselor. Our ethical codes of conduct make it clear that we provide a professional service and should not engage in befriending or personal relationships with our clients. Maintain your professionalism and leave self-disclosure at home. ◀



*Dr. Tracy Hill is a school counselor in the West Chester [Pennsylvania] Area School District. In addition, she has a private psychology practice in Malvern, PA, and teaches psychology and behavioral health at Immaculata and Drexel University. She lives in Malvern with her three children and new therapy puppy, Freud.*

# Changing The Way We View Conduct Disorder

By Brandon Yarber

Historically, the theme of stories told by those who have had encounters with conduct disordered kids, or the programs that house them, have all started with anger, which then led to aggression, which climaxed in violence. These stories pretty much have the same plot, one episode after another. Eventually, people tired of making up excuses for the vast population of kids who are misunderstood and labeled them “Conduct Kids.”

Today, the Conduct Kid still exists; he is your brother, cousin and friend. He is every teenaged kid opposed to the norms of society or the directives given by a parent and/or seeks to evade the long arms of the law. He has the potential to be wise but chooses to be misunderstood. He has the potential to be loved but chooses to be distant. He chooses nothing because, oftentimes, he has never been given a choice – or at least that’s how he sees it.

At KidsPeace, The Fulton House of the Inventor Center is changing the way that we view Conduct Disorder and challenging the belief that the Conduct Kid really exists. Traditionally, Conduct Disorder Programs have been staffed with very large, very muscular staff members who could ensure that Conduct Kids did not hurt anyone. Today, we staff with highly intelligent counselors who can reason with the boys in the Conduct Disorder program – big minds and average size bodies. We surround our kids with staff who are sensitive to their needs, experiences and interpretation of life. Our staff addresses behaviors in a non-punitive manner because we are careful not to compete with kids on turf that they know best. Additionally, we dare to expose them to a gallery of appreciation, praises and trust.

We advocate that, by building relationships with kids from the moment they enter our doors, we are instantly identified as helping agents and are allowed to aid our kids in beginning the process of change. When our kids are struggling, we do not combat the problem by offering punitive measures as a solution. Instead, we offer incentives to help our kids bounce back from sporadic episodic behaviors.

We unified both clinical and behavioral approaches to target and address the needs of Conduct Disordered kids. Treatment interventions such as Thinking for a Change, Anger Management, Motivational Interviewing and Trauma Focused Therapeutic techniques are all helpful tools. We recognize that the realities of past trauma and various social barriers affect both kids’ vulnerability and capacity for effectively dealing with change.

We are flexible and open to programming each kid differently. We do not offer any uniformed approaches to addressing our kids’ needs. Conduct Kids are intelligent (in their own right), and, therefore, we assess their interests thoroughly, despite their efforts to deter us through displays of inappropriate behaviors. We regard much of their negative behaviors as defense mechanisms or ways of communicating their discomfort or, in some cases, enjoyment.

How does the Fulton House staff use a non-confrontational/non-punitive approach to address our kids’ behaviors? We utilize a point system with realistic ratings specific to each child’s level of functioning and capacity for change. If a child has earned a consequence, staff will create incentives for them to bounce back and engage in regular programming (i.e., extra chores). Why? To avoid helping

kids dig bigger and inescapable holes for themselves. By helping kids reach positive levels, we are promoting the incentive for kids to do well, providing them with a goal and offering them hope.

Currently, the Conduct Kid is involved in a painting project that allows him access to the community and offers him the chance to learn a craft that will one day help him enter the work force. He is volunteering weekly at a family farm in the community, to help him understand the importance of giving back. He is attending weekly sessions at the local DoJo to help him learn self-discipline and healthy exercise habits. He attended a college tour, which allowed him to sit in during a class lecture and experience what very few kids in his peer groups will witness. He attended the Empire Beauty School to explore his interest and learn the steps to achieving one of his personal goals.

With our continuous efforts to assist him with his problems and shaping his identity, we even decided to stop calling him The Conduct Kid, because he is starting to look so much like a kid and behave like a young adult, we just decided to call him a success. ◀

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■ *Brandon Yarber is the House Manager of the Specialized/Conduct Disorder Program at the KidsPeace Fulton House in Orefield, PA. Brandon has a Bachelor's degree in Criminal Justice and has been with KidsPeace since 2008. Before joining KidsPeace, Brandon worked with hundreds of adolescents from DC, NJ, CT, DE, CA and NY, helping them to deal with difficult life experiences and challenges. He is currently responsible for program operations and the Child Care Counselors who are assigned to his program. Brandon works side by side with multi-disciplinary team members to individualize treatment plans for each adolescent and offer opportunities that help clients change the way they view things. He provides limits, structure and a safe/secure environment that offers all clients the support they need to work on their treatment issues.*

A photograph of a woman and a young girl sitting on a couch, facing each other and smiling. The woman is on the left, wearing a white top and blue jeans. The girl is on the right, wearing a white t-shirt and blue jeans. They are holding hands, and the woman is gently holding the girl's hands. The background is a bright, out-of-focus indoor setting.

Special Focus:

*Family Centered  
Treatment*

*Family* centered therapy is a type of therapy that works with all family members to nurture and change development. It views change in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health. It avoids characterizing one particular family member as an identified “bad child.” There are many different types of family therapy, but they share a common idea that, involving the entire family in solutions to an identified problem, is often beneficial. In recent years, therapists have learned to identify families as broadly as possible, often including grandparents, other extended family, foster parents and sometimes even case managers and teachers as part of the larger system. This change has helped clinicians identify strengths and welcome positive change.

every family is unique, in today’s world, there is constant juggling of work, school, recreation, extra-curricula activities, homework and family time, and most families experience times of struggle to keep up with all of their commitments.

There are many factors that can disrupt a well functioning family: children get sick, a parent loses his or her job, kids are bullied, separation or divorce causes a huge disruption, the family moves and money problems can alter the family’s lifestyle, while many other problems can beset a family at the same time. The problems of any one family member can turn a happy family into a dysfunctional group who no longer understand each other and are very stressed. This stress, in turn, can lead to a number of problems including unhealthy behaviors, depression, escalated disagreements, lack of communication, substance abuse and the need for counseling.

# Family

By Jason Savenelli, LPC and Nan Sell-Parry, LCSW

# cent

Because KidsPeace is always on the leading edge of trends in the mental health field, we anticipated this shift to Family Centered Treatment and directed our efforts toward reengineering our continuum of care to accommodate this change. In fact, we constructed a new building to house our community-based family therapy center, which opened in September 2010 in Bethlehem, PA. (To learn more about the KidsPeace Family Center in Bethlehem, PA, please visit our website at [www.kidspeace.org/familycenter.aspx](http://www.kidspeace.org/familycenter.aspx)).

## The Family

Because there are such strong connections among family members, if one person is sad or exhibiting negative behaviors or experiencing difficulty in school or at work, there is a negative impact on the entire family. Although

## Family-Centered Treatment

It is when stress begins to disrupt the entire family or decreases one family member’s ability to function that the KidsPeace Family Center’s outpatient services can be particularly helpful. We assist families with navigating the tough times and developing the skills they need to address and manage their problems.

Regardless of the issue or mental health disorder, Family Center Outpatient staff approach the problem within the context of the entire family. If the parents or siblings need counseling, it is provided by the Family Center. Group sessions with all family members are also arranged to work on family dynamics and to develop a strong support system for helping each other overcome individual problems.




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In addition to traditional counseling and treatment, therapists use art, games and play, teaching and talking to build the skills needed to learn and heal.

Psychiatrists are available to evaluate and diagnose clients and to prescribe medication if needed. The KidsPeace team of therapists, doctors, parents and children works together to make the family stronger and healthier.

Throughout the Continuum of Care at KidsPeace, our treatment approach integrates the family into the entire process so that the children and teens can continue to progress at home after a stay at our Psychiatric Hospital, Residential programs, Partial Hospitalization programs or Foster Care. Indeed, a stay in Foster Care may be extremely helpful while the child participates in individual and family therapy at our Family Center.

We teach families to get along, settle disputes without violence or verbal escalation, get help for substance abuse,

and finances were strained. The therapist set up an assessment for the mother and started to see her individually, adding marital therapy as well. The mother started to see the psychiatrist who prescribed an anti-depressant. Now, the family has stabilized, the child's behavior has improved and the family has been successfully stepped down to monthly maintenance sessions.

Family centered treatment is a helpful way of treating identified children and their families by assisting the entire family system. In practice at KidsPeace, this treatment modality helps kids and families to change without needing to resort to higher, more intrusive levels of care such as hospitalization or in home treatment. ◀

# Therapy

stop arguing with each other, learn to spend time together and communicate effectively. As the family becomes more functional, so does the child who was initially referred to the program.

For example, a family recently brought their young son in for an assessment when the child behaved aggressively at home and at school. The child enjoyed coming to counseling and saw the psychiatrist for a low dose of medication. As the therapist got to know the family in family sessions, he discovered that the mother was experiencing sadness and hopelessness that had nothing to do with her son, but everything to do with her own struggling marriage. The situation was fueled by alcohol abuse and displays of temper between the parents that the children could see. The mother was not able to manage the household anymore,



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# Setting the Course



By F. Dave Williams, MSW, LCSW

Special Focus

## for Family Centered Treatment

*As* a counselor who works with children and adolescents, I have found that the more a family is empowered with education and support at the onset of counseling (upon intake), the less resistance the therapist faces during the various phases of treatment. This article describes some techniques for setting the course for family centered treatment.

Not everyone seeking counseling knows what family centered treatment is; nor are they aware of how family centered treatment will unfold in terms of the counseling process. During the initial interview, it is common for parents to describe their child's behavior within the context of the child's relationships with others (friends, parents, siblings, teachers, coaches etc.). Therefore, it is critical in that first meeting to educate both the parents and the child as to how family dynamics can impact a child's behavior, which highlights the true need for family centered treatment. Parents learn how family dynamics can present difficult challenges for their child. They also learn that, within the same family dynamics, many resources and strengths exist, which can be cultivated to better leverage positive changes. This education for parents and other family members is invaluable because it sets the therapeutic tone and allows members of the family to understand their critical role in promoting the change process.

Frequently, it is important during the initial session to let parents know that the counselor may ask to see them without their child present and may also need to know more about their marriage, when appropriate. There may be a need to see all of the family members in different groupings, which could include siblings and even extended family members who are involved and/or residing in the home. It is important that counselors attempt to establish the nature and extent to which family dynamics are negatively influencing the child's individual functioning and determine if there are any unknown stressors

that could be damaging to the child if not addressed. The counselor should also seek out untapped resources that exist within the family system and work to identify and mobilize them for the family. Once these dynamics are assessed, a plan is developed in collaboration with the family.

Members of the family often need to be comforted early on and reminded that family centered treatment is most effective when members are committed to doing what works - not just what is comfortable for everyone. Many times, parents have to be convinced that their child's behavior isn't occurring in a vacuum and isn't likely to be assessed, understood and changed in a vacuum.

### *The Story of Bill*

The story of Bill illustrates a situation in which a child was brought for services and was initially opposed to the idea of family centered treatment. His parents were also resistant to becoming involved in their son's counseling. Despite several attempts to initially educate them as to the need for a family centered approach, Bill and his family resisted.

Bill was a bright but guarded 12 year old who was failing at school, acting out at home, depressed and had recently made suicidal threats. During the first meeting with Bill, he reported that his father had been abusive both physically and emotionally toward him for many years. His mother was a victim of domestic violence at the hands of her husband and, unfortunately, Bill witnessed many of these violent episodes. Even though the physical violence had ended some years ago, Bill reported that, as long as he could remember, his parents were either fighting or ignoring each other. We developed a rapport around some of the more surface level issues like school work and peer relationships, but his depression, behavioral acting out and a growing feeling of hopelessness continued.

During individual work with Bill, he reported ongoing chaos in the home. After about three months, it seemed obvious that individual counseling wasn't meeting Bill's needs. Reluctantly, Bill agreed to participate in family counseling, which instigated reaching out to the parents and inviting them in. While they were initially resistant, they were open to new ideas given Bill's continued decompensation despite a few months of counseling.

Over the course of continued individual work, many family counseling sessions and some attempts at marital counseling, a strong dysfunctional theme became obvious. Because of the trauma Bill witnessed and his resultant feeling of powerlessness, Bill developed a sophisticated set of behaviors: When he sensed a potential problem emerging between his parents, he acted out in an attempt to prevent a recurrence of the traumatic scenes he recalled from earlier in his childhood. This distraction tactic went unnoticed by his parents, who were lost in the complexities of their own individual and marital problems. The more his parents' marriage destabilized, the more Bill would act out to attempt to compensate. Bill had developed this pattern over time as he witnessed many scenes of domestic violence during his formative years. Ultimately, the more he became entangled in his parent's marital problems, the more he acted out, in proportion to the discord that existed between his parents. For the parents, Bill's problematic behavior served as a distraction from their failing marriage and abusive relationship. Over time, Bill's depression worsened from the stress of this balancing act.

With some time and counseling, the parents began to understand how their troubled marriage, as well as the violence in their home, had impacted Bill's social, emotional and behavioral development over the years. Family work continued to target identified systems issues that contributed to Bill's difficulties. It was agreed that individual counseling alone would not adequately address their son's behavior because the origin of his behavior was directly tied to dynamics in the family system. The parents struggled with marriage counseling but found some

relief in their own individual counseling, as each parent had many years of emotional baggage to examine.

Bill began to recognize some of these dysfunctional themes playing out in his own life (school performance, peer relationships and his overall depression). It was difficult for him to begin making better choices; however, as his parents began to change their dysfunctional behavior, he found it less painful to examine the true nature of his problems.

In counseling, he worked his way toward the realization that some of the only times he felt loved and important were when his parents were upset with him. He found himself consistently seeking the negative attention of his parents, his peers and his schoolteachers in order to feel accepted and included. As some of his behaviors stabilized, Bill developed better verbal skills and gained the confidence to express his needs and feelings in a more healthy way. In family work, Bill began expressing much of the anger he had been holding onto for years, which seemed to be the source of his ongoing depression. Bill found some relief in antidepressant medication, which provided additional support during this difficult segment of the healing process.

In her own counseling, Bill's mother began to see that, under the stress of the chaos in the home, she had developed an unhealthy relationship with her son. In the aftermath of these crisis episodes, she would befriend Bill and share adult information with him, which later made it difficult for her to parent Bill when he was acting out. With the support of counseling, she was able to change this dynamic and learn how to lean on her adult support system, which opened doors for new parenting experiences with Bill.

Bill's father struggled with his own mental health and, in his own counseling, worked to understand how his abusive childhood was playing out in his current family relationships. Bill's father began learning how to control his anger and deal in a more healthy way with his own feelings of guilt related to the past.

Both parents have learned how to show affection and pay attention to Bill in a

positive way, while also learning how to talk about the past in a way that leads to continued healing. For Bill's family, the most difficult times come about when the regular stresses of life pull one or more of them back into old patterns of behavior. Family sessions are less frequent but occur when one of the family members feels they need a "tune up." Bill's conduct has improved both at home and in school. He remains in individual counseling where he works to better understand boundaries in relationships while also developing increased insight into his own self worth.

In this case, Bill's behavior was clearly more accurately assessed thanks to the framework of a Family Centered Treatment model. Addressing Bill's issues in individual counseling alone would not have led to uncovering, understanding and working toward the restructuring of family dynamics which were so central to the perpetuation of his problematic behaviors. ◀



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By Jason R. Victory, MS, NCC, LPC, ACS, Clinician

# Effectiveness of Family Centered Therapy for Residential Treatment Facility Clients

*With* a background of more than 13 years in the mental health field, I have had opportunities to work with clients in various levels of care, including outpatient therapy, school-based partial hospitalization programs, acute partial hospitalization programs, group home programs and residential treatment facilities. It is clear in all of these settings that recidivism and relapse are very high in the programs that do not include Family Centered Therapy as a modality. The main reason is basic: If the child or adolescent makes significant progress and experiences change, but does not have significant people or an environment that supports these changes, he will more than likely regress to the level of functioning that precipitated his most recent level of care.

## *Families*

The young people I see in residential programs come from diverse backgrounds and present with varied psychiatric and behavioral needs and diagnoses. One factor they have in common is the need each resident has for family and family support. Each

resident identifies family in her personal manner, be it blood relations, foster families, adoptive families, peer groups, caseworkers, etc. Additionally, each resident derives emotional support of some sort from his “family.”

Just as they vary in composition, families vary in terms of the levels of support they provide to their children during residential treatment. Some are enmeshed, which means that emotional and physical boundaries are violated. Some are aloof and emotionally detached for different reasons. Yet others are invested and simply need structure and guidance to support the needs of their children.

Enmeshed families clearly need outside agency supervision to ensure no form of abuse occurs. At times, therapy includes helping children and adolescents and their families develop insights into the problematic nature of the enmeshment. At other times, due to the degree to which boundaries have been violated, re-defining family is necessary when children and adolescents are placed into new environments away from the enmeshed families that have exacerbated and, at times, created the disturbances that necessitated treatment.

Regardless of the level, Family Centered Therapy has proven an effective modality in the treatment programming of the young clients in residential treatment programs. Family Centered Therapy must include elements of:

- Psycho education of the diagnoses
- Causes of and contributory factors to the diagnosis
- Parenting interventions
- Communication skills
- Reinforcement scheduling
- Medication education
- Restructuring of expectations
- Self-modulation and self-awareness of reactions of each family member
- Self-care skills of each member
- Role identity clarification
- Clinical homework assignments to be completed during on and off grounds visits
- Analysis of the problematic behaviors and motivational factors to modify said behaviors
- Identification of barriers to success and methods of proactively managing the barriers.

*Family Centered Therapy can prove to be particularly effective when the clinical team implements unique, individualized interventions.*

Further, each element needs to be individualized to the personality and cognitive functioning levels of the child/adolescent. When Family Centered Therapy addresses these elements, it complements the individualized clinical work each resident completes during her or his treatment program to sustain the progress within the home.

Psycho education about the diagnoses can assist to alleviate feelings of guilt, remorse and embarrassment by the child/adolescent and family members as they gain insights regarding the organic, internal and external factors that contribute to and cause the foci of treatment. Communication skills need to include verbal and non-verbal language to help each member learn to speak openly with each other without triggering defense mechanisms. An integral part of communication and interventions is self-regulation, to wit, awareness of internal reactions to others and learning to respond to one another appropriately rather than irrationally.

Additionally, role identification is crucial to healthy family relations as well, as each member learns how the role she or he has adopted has contributed to the problematic and positive relations/interactions within the family. Each member becomes educated about structuring roles based upon meeting the needs of every other member. Psycho education regarding developmentally

appropriate reinforcement schedules is imperative so that family members are able to provide motivational interventions that meet each child/adolescent's emotional and behavioral needs to help them function within their communities. Self-care skills of clients and their family members need to be taught, role-modeled and practiced daily so as to become intuitive rather than guided. These self-care skills, reinforcement schedules and communication skills are practiced during family therapy sessions and on and off grounds visits.

Family Centered Therapy can prove to be particularly effective when the clinical team implements unique, individualized interventions. Clinical team members are educated regarding trauma reactions so they are able to implement interventions that are effective and do not replicate unhealthy family dynamics.

Clients are able to learn how to restructure their behaviors to achieve personal educational and vocational goals, rather than continuing to re-enact defense mechanisms that have caused them to not relate appropriately within their communities. Clinical team members can provide unique programming including off grounds work on farms, field trips to colleges, art projects, talent shows, engagement in martial arts and many other opportunities. They then must educate families about how to replicate such programming

within the family home to help the child/adolescent realize her or his personal strengths.

Family sessions can occur on the grounds of the facility or within family homes. This combination of locations offers individualized treatment and allows the child/adolescent and family members to utilize skills within their natural environment and the residential environment. Family Day can also be helpful because families are able to interact with their children/adolescents and other families to develop a sense of community. During Family Day, educational group sessions are typically provided to further educate families regarding the aforementioned elements.

Another element that can be critical to Family Centered Treatment is unique approaches to serving the community with an open-minded approach to working with children, adolescents, families, agencies and communities. Treatment teams should also be open to feedback and, therefore, programming and clinical interventions that are individualized and continually evolving to meet the psychiatric needs of the clients/residents.

Finally, the team must take a truly Strengths-Based approach with families. Many of the families whose children are in residential treatment feel stigmatized and downtrodden due to the difficult road they have traveled with their children. The treatment team can tailor therapy sessions and treatment planning to focus on using family and client strengths to overcome the child's presenting problems. Programming and aftercare must also be tailored to address their strengths, thus enhancing self-efficacy and significantly decreasing recidivism and relapse. ◀



*Jason Victory is a Clinician at the KidsPeace Inventor Center in Orefield, PA, where the techniques discussed in this article are successfully implemented to treat children and adolescents in residential*

*care and return them to their families. This emphasis on Family Centered Treatment reduces the time spent in residential and strengthens support systems after return to their family settings.*

# F a m i l y

## *involvement*



### Family Centered Treatment at KidsPeace New England

By Jean Dixon Former Director of Education and Residential Services

*When* the KidsPeace New England campus first began its residential autism program, one of the main focuses in the design was family involvement. This was new to us, but working with children on the autism spectrum has changed everything. These kids are different, and so are their families. As a result, they require a different approach. Parents and families of children on the spectrum are exhausted, desperate, afraid, seeking support of which there is very little in the community, frustrated, judged and too often discouraged and feeling “alone without hope” ... their words not mine. But it is not just the autism families who are now involved in our treatment center. It is all families, regardless of the program.

I believe we do a disservice to ourselves and our families and their children when we label ourselves a “family centered treatment” center. I prefer “family involved” treatment center. That is really who we are and how we should be. It is the philosophy at the KidsPeace New England campus, and it is working. Parents and siblings are part of the KidsPeace family; better yet, we are more a part of theirs.

Some of our parents and families are on campus daily to see their children. One is on campus every morning during breakfast. One comes every afternoon and brings her other son to visit his brother. One comes weekly because the travel distance is so far. One parent just lost her phone and her vehicle, so we take the kids to her each day. She has two children in our program. Some of our Day Treatment parents stop into the school each morning to speak to the

teachers and Ed Techs. But it is so much more than that.

We have one mother who is a beautician. She gives haircuts to all the kids on the spectrum who are not yet able to go to a barbershop or salon. She brings her other son with her, and he plays with the kids while his mother gives the haircuts. I remember one Saturday walking onto the residence, and several kids were at the table eating a snack. I looked at each one around the table and thought, “that one is not one of ours.” I then realized it was a brother and he was having such a great time with the other kids while his mother did haircuts. Family involvement at it’s finest.

A mother of one of our non-verbal boys requested we set up a computer on the residence for him so they can communicate with each other online and visually using webcam when she can’t make it to campus. Of course we did it.

Several parents come in weekly at dinnertime and eat with their children. One night, a parent brought her sister, two nephews and her other two sons to dinner. Her son is non-verbal autistic and was not able to sit at the table with his guests, but the family had a great time visiting at the table next to him. What is especially nice about these events is that they are not planned. The families are welcome to come at anytime to see their children. They do not need to call ahead, make an appointment or clear their visits with anyone. We encourage that, and they appreciate the open door and open hearts.

Some of the activities we offer are off campus. For example, for the past six years, we have volunteered weekly at Great Pond Mountain Conservation Trust, building trails, planting trees,

building bridges and learning about the outdoors. Parents are welcome to join in this activity with their children, and some do.

Parents are in the residence and on campus at any time. Many know the other kids’ names and all the staff member names. I have seen them redirect other children. That is comfort and that is the family involvement and atmosphere we strive for. What is really nice is when two or three of the parents are on campus at the same time, and they get together and chat in the dining hall over coffee. I’ve seen it, and it is as though they have known each other forever. They get their own coffee. They get their own snacks. They are family and need not ask. This is their home as well as their child’s. It works best this way.

One child with autism in our day treatment program was transitioned into our residential program last fall. If you think it is easy to release your child into residential care, this family can tell you different. We spent over two months preparing for the transition. We went to the family’s home, and his home workers came to campus. Our ABA staff worked with the family for months to prepare for the move. We duplicated his bedroom at home with his new room on the residence. Same wall color, same closet set up, same bedding, etc. We even created a separate living area like the one he had at home where he had a couch, TV, desk, etc. Again, same wall color. He began spending small bits of time in the residence during the day, then came to visit on the weekends, and finally he stayed. We invited his mother to spend the first couple nights. It was a wonderful and successful transition, and, frankly, it

was as much about the mother's comfort as it was the child's. We felt good about that transition, and so did she. She is like family now.

Not all parents are involved. Not all can be. We make the effort to do all we can to get them involved. They are always invited. Sometimes families can only call in to a meeting, but the key is respect and inclusion, sharing and learning about their child from them, and teaching them what we have learned about their child. They have put their child in our care, and we have the responsibility to provide the best no matter how much they can or want to participate. Kindness and taking time to build relationships is just as important with the family as it is with the child.

Family involvement on the business side of KidsPeace New England is in place as well. We often invite legislators and guests to the campus to see and hear about our autism program. We have found that, if these visitors hear from the parents and families directly, they get a deeper understanding of the needs of both the children and the families. They tell their own story. We just give them the venue.

We were very fortunate this past summer to have Senator Olympia Snowe come to our campus. One of our parents joined us. She assisted in a tour of the facility, brought Olympia gifts her children had created, and brought to life what most people do not understand. She talked about what life was like for her with two children on the autism spectrum prior to coming to KidsPeace.

"KidsPeace saved my life." She told Olympia. You don't necessarily get that from a family centered treatment facility. You get that from a family involved treatment facility.

We love families. They have made KidsPeace New England what it is today and what it can be in the future for their children. We are now working toward establishing a Parent Advisory Board. ◀

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“OFTEN WE HAVE SAVED FOSTER CHILDREN FROM ABUSE, BUT WE HAVE FAILED TO RECOGNIZE THAT THEY STILL CARRY WITH THEM THEIR FEELINGS AND MEMORIES OF THEIR BIOLOGICAL FAMILIES AS THEY TRAVEL THROUGH THE FOSTER CARE SYSTEM.”



# THE AMBIGUOUS FOSTER CHILD

By: Susan S. Cornbluth, Psy.D.

## AMBIGUOUS LOSS

Have you ever lost something you know still exists? Perhaps it was an old picture, a sentimental letter or your favorite pair of shoes. Initially, you search and search for the item but you cannot recover it. It eats away at you, day after day, until you are lucky enough to be reunited with it. When this happens, you give a big sigh of relief, the panic eventually subsides and you move forward with your life.

This same scenario can apply to children in the foster care system. They have been separated from what is most precious to them, their families. They know that their family members still exist, but they cannot live with them. Clearly, those children who are reunited with their families feel a great sense of relief. The children who remain in care hold onto the hope of reunifying with their families as long as they are in foster care. Their losses are unresolved.

Ambiguous loss is also known as an unresolved loss. Boss, 1999, defined ambiguous loss as the grief or distress associated with a loss (usually a person or relationship) in which there is confusion or uncertainty about the finality of the loss. There are two types of ambiguous loss:

1. When the person is physically present but psychologically unavailable. An example of this might be when a child's parent has a mental health diagnosis or a substance use issue that makes him/her emotionally unavailable to meet the needs of the child, even if that parent is physically present.
2. When the person is physically absent but psychologically present. Examples of this would be when a child does not live with a parent due to divorce, incarceration, foster care or adoption (Boss, 1999).

For children in foster care, ambiguous loss occurs over and over again and is very difficult to process. Children who enter foster care often lose contact with their birth parents, their siblings, other family members, friends and their physical surroundings. They enter uncertain situations and are left wondering if the separation from their biological families will be permanent or temporary. Frequently, the biological family stays psychologically present in the child's mind, even though the biological family members are not physically present. While in care, many foster children fluctuate between hope and hopelessness with regard to reunification. This is due to the ambiguous loss, which causes them to block themselves from forming healthy attachments to their new foster families. To gain a better understanding of a foster child experiencing an ambiguous loss, consider the example of this 11-year-old boy who was in foster care:

*I knew that my mom kept thinking about getting us back and that helped me hang on. She told me she wanted us back. I just could never give up on my mom even though she did so much stuff. I know no matter what she put me through she still loved me. There was no way I was going to call my foster mother Mom. I got a mother. At times my mom said she couldn't stop thinking about us and wanted to kill herself because she wasn't with us. I thought one day she will come back and get me, wake up and realize what she did wrong. After all the pain you go through you hope there is happiness waiting for you in the end (Manuel, age 11).*

Nationally, there are 463,000 children in foster care, 49% of whom are slated for reunification with their biological parents. With this in mind, it is essential that professionals working with foster children and foster parents understand the concept

of ambiguous loss and work with their clients to create more stable relationships between foster parents and their foster children ([www.childwelfare.gov](http://www.childwelfare.gov)).

## HOW FOSTER PARENTS CAN COPE

Ambiguous loss can be difficult for many foster parents to comprehend if they do not have a clear understanding of its role in the foster child's life. As outsiders, we expect the foster child to be as angry as we are at the biological parents who caused them pain. We cannot understand why the children want to have anything to do with their biological parents after being treated so badly. This may be our reality, but it is not the foster child's reality. Extreme loyalty remains between the child and the biological family members, and hope of returning home is kept alive by phone contact or visits with biological parents who tell them that they are attempting to regain custody. These statements by parents underscore for the children that reunification is not a fantasy; it can be a reality. Since the loss is unresolved, the children find it very difficult to detach from their biological parents and attach to a new caregiver; their parents are still very much alive.

Foster parents can ease the transition for themselves and their foster children by recognizing the symptoms of ambiguous loss prior to the child entering the home. These symptoms often include:

- Difficulty with changes and transitions, even seemingly minor ones like sleeping in a new bed
- Trouble making decisions
- Feelings of being overwhelmed when asked to make a choice

- Problems coping with routine childhood or adolescent losses (last day of school, death of a pet, move to a new home, etc.)

- A sort of learned helplessness and hopelessness due to a sense that he has no control over his life
  - Depression and anxiety
  - Feelings of guilt
  - Fear of attachment
  - Lack of trust.
- ([www.nacac.org](http://www.nacac.org))

Foster parents can also help alleviate the ambiguous foster child's anxieties and fears and create a healthy attachment by:

- Acknowledging that the foster child's biological family still exists; denial can be a real enemy.
- Not taking sides but spending time exploring the foster child's feelings if he is open to this.
- Giving a voice to the ambiguity -- give a name to the feelings of ambiguous loss and acknowledge how difficult it is to live with this ambiguity.
- Learning to redefine what it means to be a family, both foster and biological.
- Giving your foster children permission to have feelings about being separated from their family of origin without feeling guilty.
- Helping the child identify what has been lost (the loss may not be limited to the actual parent – loss could also include the membership of that extended family, the loss of the home or town, the loss of having a family that looks like them or the loss of their family surname.
- Create a “loss box.” In her work with adopted adolescents, therapist Debbie

Riley guides youth as they decorate a box in which they place items that represent things they've lost. This gives them both a ritual for acknowledging the loss and a way for them to revisit the people or relationships in the future.

- Creating a life book and writing in the birthdays and names of their biological family members.
- Understanding that sometimes certain events trigger feelings of loss, such as holidays, birthdays or the anniversary of an adoption. Alter or add to family rituals to acknowledge the child's feelings about these important people or relationships that have been lost. For example, adding an extra candle representing the child's birth family on his or her cake may be a way of remembering their part in your child's life on that day.
- Don't set an expectation that grief over ambiguous loss will be “cured,” “fixed” or “resolved” in any kind of predetermined timeframe. Explain that feelings related to ambiguous loss will come and go at different times in a person's life and provide a safe place for the child to express those feelings ([www.nacac.org](http://www.nacac.org)). ◀

In addition to unconditional love, the best gifts that anyone can give a foster child coping with an ambiguous loss are patience, honesty and acknowledgement.

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*specialization in Marriage and Family Therapy. Dr. Cornbluth received the award of Who's Who Among Teachers and Educators in 2007 and has worked extensively with and provided psychotherapy to children in the Philadelphia foster care system. She was also chairman of the “Traveling Kids Program” in Philadelphia, which provided suitcases to foster children in need. Dr. Cornbluth's training manual titled, “The Ambiguous Foster Child: Attachment, Separation, Loss and Loyalty,” was released in May. She is also in the process of writing her first children's foster care book.*



# KIDSPeACE OFFERS HELP IN REASSURING CHILDREN AFTER NATURAL DISASTERS AND SCHOOL SHOOTINGS

## FOR EDUCATORS:

*To help school systems see the early warning signs of danger and deal with the psychological fallout of disasters or shootings, KidsPeace offers several articles in past issues of Healing Magazine, including “Building Resiliency in Traumatized Kids: Coping with 21st Century Realities,” “Can School Shootings be Prevented?” “Providing Comfort to Adolescents in Times of Crisis” and “Helping Educators Identify Potential School Shooters.” These can be found at [www.healingmagazine.org](http://www.healingmagazine.org). In addition, KidsPeace offers highly trained professionals who counsel children and teens on outpatient, residential or inpatient levels.*



Natural disasters such as the one we witnessed recently in Japan are disturbing to all of us as we watch helplessly as people lose their lives and their homes. The added threat of nuclear power plants releasing radiation is frightening and the topic of great discussion among adults. Japan was the primary topic on many television and radio broadcasts, this spring, with many “experts” talking endlessly about the dire consequences of the power plant explosions.

Our children and teens cannot help but be exposed to some of this information, and many of them may become traumatized by the scenes of devastation and discussions about nuclear power safety. Many teachers are talking about the events in school, which leads to kids talking about it among themselves, often not understanding how far away Japan is. They become very concerned that a similar disaster will occur where they live. They worry about being separated from their families, having their homes destroyed and losing friends and relatives in similar fashion.

It is important to recognize that children may not talk about their fears, allowing the worry and fear to become serious contributors to trauma. The following 10 Tips will help parents and educators talk to their children honestly about such events and watch for signs that their children are traumatized.

For more detailed information on helping children and teens deal with natural disasters, explosions and fires and acts of violence, please download the Healing Magazine Crisis Kit at [www.kidspeace.org/naturaldisasters.aspx](http://www.kidspeace.org/naturaldisasters.aspx). It is in PDF format and free of charge. Also recommend that teens log onto TeenCentral.Net for expert advise from Master’s and doctorate level counselors on this issue or anything that may be bothering them. Parents may log onto ParentCentral.Net for assistance with any parenting issues they may be experiencing.

# 10 TIPS FOR TALKING TO CHILDREN ABOUT NATURAL DISASTERS AND SCHOOL SHOOTINGS

The effects of trauma in children may linger and manifest themselves physically and behaviorally. Will Isemann, President of CEO of KidsPeace, and the clinical experts at KidsPeace have compiled a list of tips to help parents talk to their children about what has happened to upset them and look out for future signs of distress:

**1.** Listen to children. Allow them to express their concerns and fears.

**2.** Regardless of age, the most important issue is to reassure children of safety and security. Tell children that you, their school, their friends and their communities are all focused on their safety and that those around them are working for their safety. Have discussions about those dedicated to protecting them like police, teachers and other school officials, neighbors, their government and all concerned adults throughout the community.

**3.** When discussing the events with younger children, the amount of information shared should be limited to some basic facts. Use words meaningful to them (not words like massive devastation or sniper, etc.). Share with them that weather or geological shifting has caused a specific disastrous event in a certain part of the world or some bad people have used violence to hurt innocent people in the area. Discuss that we don't know exactly why this has happened, but a natural disaster or violence has occurred. Do not go into specific details.

**4.** School-aged children will ask, "Can this happen here, or to me?" Do not lie to children. Share that it is unlikely that anything like this will happen to them or in their community. Then reiterate how the community is focused on working to keep everyone safe in the community.

**5.** Parents, caregivers and teachers should be cautious of permitting young children to watch news or listen to radio that is discussing or showing mass death or carnage. It is too difficult for most of them to process. Personal discussions are the best way to share information with this group. Also, plan to discuss this many times over the coming weeks.

**6.** When discussing the events with preteens and teens, more detail is appropriate, and many will already have

seen news broadcasts. Do not let them focus too much on graphic details. Rather, elicit their feelings and concerns and focus your discussions on what they share with you. Be careful of how much media they are exposed to. Talk directly with them about the tragedy and answer their questions truthfully.

**7.** Although this group is more mature, do not forget to reassure them of their safety and your efforts to protect them. Regardless of age, kids must hear this message.

**8.** Be on the lookout for physical symptoms of anxiety that children may demonstrate. They may be a sign that a child, although not directly discussing the tragedy, is very troubled by the recent events. Talk more directly to children who exhibit these signs:

- Headaches
- Excessive worry
- Stomach aches
- Increased arguing
- Back aches
- Irritability
- Trouble sleeping or eating
- Loss of concentration
- Nightmares
- Withdrawal
- Refusal to go to school
- Clinging behavior.

**9.** Parents and caregivers should often reassure children that they will be protected and kept safe. During tragedies like these, words expressing safety and reassurance with concrete plans should be discussed and agreed upon within the family and can provide the most comfort to children and teens.

**10.** If you are concerned about your children and their reaction to this or any tragedy, talk directly with their school counselor, family doctor, local mental health professional or have your older children visit KidsPeace's teen help website, [www.TeenCentral.Net](http://www.TeenCentral.Net), which provides anonymous and clinically screened help and resources for teen problems before they become overwhelming. ◀

# 7 Standards of Effective Parenting

*Every child has fundamental needs that must be met for an emotionally and physically healthy life. Every child must be able to feel safe and secure, loved and valued, able to trust and free to be a child.\**

*These needs must be met by a parent or an adult guardian. While there are many roads to effective parenting, with varying styles and methods, experts agree that all positive parenting rests upon the attribute of love. In parenting, let love be your guide. To help parents grow emotionally and physically healthy children, KidsPeace® offers these 7 standards of effective parenting.*

**1. Value your child.** Effective parents always treat their children as valued, important and worthwhile people. These parents are intent on building up their children's self-esteem through honest praise and age-appropriate levels of independence. These parents understand their children and are always loyal to the best desires, instincts and dreams their children possess.

**For example:**

- Tell your child you are proud of her.
- Praise your child for doing a good job, for completing a task.
- No matter what happens, tell your child you love him.

**2. Nurture your child.** Effective parents consistently display love for their children through positive touch (hugs, kisses, holding close), through eye contact and through positive words of encouragement and support. Effective parents tell their children, "I love you" – verbally, physically and emotionally. These parents frequently spend time with their children.

**For example:**

- Look directly at your child when she talks to you.
- Respond physically – with a hug or gentle pat on the shoulder – when your child tells you a story or concern.
- Physically comfort your child when he is frightened or ill.
- Show pleasure in your child's accomplishments with a hug or pat on the shoulder or through verbal affirmation.

**3. Teach your child.** Effective parents recognize that much of a child's learning comes from the parents' actions and words. Effective parents are flexible and adaptive, sensitively challenging their children to grow cognitively, socially and emotionally – appropriate to their children's age and development.

**For example:**

- Teach by living. Model a positive life by being positive yourself.
- Treat your children as you would like them to treat themselves ... and you!
- Encourage your child to talk to you about a problem. Tell your child about a similar struggle you have had and what you did to solve it.

**4. Speak the truth.** Effective parents do not knowingly tell falsehoods or intend to deceive, but build trust by speaking the truth in love. Effective parents realize it is sometimes better to say little or nothing and allow their children to trust than to lie and undermine confidence. Establishing a trusting relationship with your child will make it easier for your child to confide in you.

**For example:**

- If you don't know the answer to a question, say so; then find a source that will give the answer.
- Be someone your child can trust and come to for answers to difficult questions.
- Tell your child you are proud of her for sharing concerns and questions with you. Try not to act shocked or upset when your child shares sensitive thoughts or experiences with you.

**5. Discipline your child.** Effective parents offer compassionate, consistent and honest correction. These parents are not quick-tempered and do not hold a grudge or keep a record of wrongs. Instead, these parents offer reasonable and clearly understood guidelines for their children to follow. Through patience and gentle but firm actions and words, effective parents guide their children's growth and moral reasoning.

**For example:**

- Make and explain simple, age-appropriate rules for your child.
- If a rule is broken, discipline with a consistent, safe punishment like a short, quiet time alone without play.
- Parents do get angry. It is okay to let your child know you are angry at his behavior.
- If feeling overwhelmed, call a friend. Get help.

**6. Encourage your child.** Effective parents always look out for the interests and needs of their children first, before their own. They are constantly alert for the physical and verbal cues infants and children give. These parents always seek to understand their children's growth and to respond appropriately to meet the needs of their children. They care as much for their children as they care for themselves.

**For example:**

- Spend time with your child doing things he enjoys.
- As you see your child developing a particular interest, encourage her in the way her interests and abilities show.
- Help your child get started, then allow more independence.
- Read a book together, a chapter each night.
- Go for a walk together once a week.
- Cook a favorite meal together, or go out to dinner with just your child once a month.

**7. Never give up.** Effective parents admit their fears and faults. In times of crisis, or when unsure what is right or wrong, effective parents do what they think and feel is best. These parents create a network of informed friends and professionals to whom they can turn for help and advice.

**For example:**

- Realize there is no single "right" way to parent.
- Challenge yourself to find new and different solutions to problems.
- Talk to friends and to other parents who have experienced your struggles about ideas for helping.
- Call a counselor. Every parent needs help and understanding. It is available, so ask for it.

*\*These include the parent's responsibility to provide, as best as possible, basic needs such as adequate food, clothing, shelter, medical care and educational opportunities.*



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**Managing feelings and moods**, especially negative ones. This means being able to deal with anger, jealousy, grief, hatred, embarrassment, resentment, boredom or fear proactively and learning to recognize and control impulsivity.

Throughout a child's education, it is likely that he will be tested repeatedly on reading, writing, math and other supposedly measurable gauges of his learning, growth and cognitive intelligence. But it is also likely that much less emphasis will be placed on his social and emotional intelligence. And social and emotional intelligence may be a bigger determinant in a child's long-term success in life than cognitive intelligence. The skills embodied in what is called Theory of Mind are skills in which many children experience significant deficits: executive function (time management, planning, ability to focus and attend, memory management), critical thinking (sorting, comparing/contrasting, applying concepts, information and ideas) and social pragmatics (ability to take the perspective of another person, initiate and sustain interactions, problem-solve interpersonal disagreements). Lack of these skills is more likely to get us fired from a job or evicted from an apartment than is an average IQ.

The teaching of social and emotional skill should be as much a priority as is cognitive learning. We begin by defining the components of social-emotional intelligence:

**Perspective-taking** is the ability to identify feelings in both one's self and others, understanding and managing the link between our feelings and our words and actions, and experiencing empathy as both the ability to care about another and being able to demonstrate that caring in an appropriate manner.

**Forming and sustaining relationships** requires understanding the context of different relationships and that all relationships are matters of degree. It includes the skills needed to be able to learn and work as part of a group.

Opportunities to help children develop social and emotional intelligence are all around, all the time. They come from our own personal experiences and from the events that unfold in our community and the world at large. They can be gleaned from stories and books we read and from movies, TV shows and commercials. It is never too soon to start teaching social competence. From as early an age as possible, weave social-emotional awareness into your child's everyday life in a manner that is natural and doesn't come off as "instruction." There are myriad ways to do it. It starts with your own commitment to being positive role models. Modeling empathy, friendship and anger management through your own behavior gives the child something concrete to emulate.

**Talk about feelings in your daily life.** Tell him how you feel; ask him how he feels. Ask him how he thinks others might feel in given situations. Talk about how facial expressions and body language convey feelings, and call attention to these kinds of communication when they occur, both in his daily routine and in television or movies.

**Help him build a vocabulary of words describing emotions and feelings** so he can not only recognize those feelings in others, but also advocate for himself. When your child tells you he is feeling bad, probe deeper. He's taken a great first step in self-advocacy, but it is even more helpful if he can tell you that "bad" means confused, angry, hungry, frustrated, physically unwell, sad or anxious.

... remember that the most important tool you can give a child in the long process of learning empathy and self-regulation is strong, stable relationships with the key adults in his life.

# Other Intelligence

By Ellen Notbohm

**Acknowledge and reward progress and effort**, however small the increment. Tell him, “I like how you let Evan go first” - even if he did it under duress and complained for a full ten minutes without taking a breath.

**Offer more than just discussion.** Look for graphic materials that promote social competence. These might include computer games, board games, DVDs, books, children’s museum exhibits. Being able to come back to the material again and again, having it be the same each time, and being able to keep it in front of him for as long as he needs to study it – all these components enhance learning immeasurably.

**Encourage your child or student to keep a feelings journal.** One sentence or drawing a day or a few times a week is enough to start. If he isn’t writing yet, he can dictate to you, talk into a recording device or even just paste facial expression stickers on a blank calendar. Part of the journal might be a running list of people, places and activities that inspire positive emotions in him. He might also include a list of people, places and activities that provoke negative emotions in him.

This list can be a good starting point for a discussion of how to avoid or cope with troubling persons or situations.

**Incorporate a focus on giving compliments into everyday life** at home or in the classroom. Provide a bulletin board or large jar where classmates or family members can post or deposit compliments. Set time aside each classroom day, dinnertime or other group time to read and applaud.

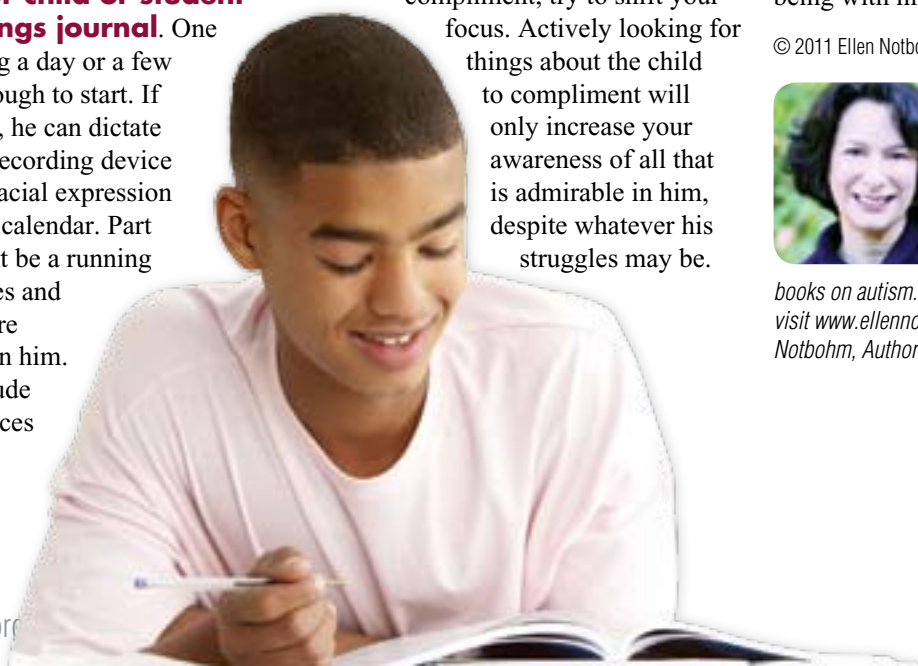
Many educators and psychologists today advocate an 8-to-1 praise-to-criticize ratio as necessary for encouraging children to change a behavior. Impose an informal praise quota on yourself, and, if you find yourself criticizing more than you compliment, try to shift your focus. Actively looking for things about the child to compliment will only increase your awareness of all that is admirable in him, despite whatever his struggles may be.

And finally, remember that the most important tool you can give a child in the long process of learning empathy and self-regulation is strong, stable relationships with the key adults in his life. A child learns and grows by doing, but, long before he can do that, he learns and responds to his environment in the context of how it feels to him. We all know from personal experience that emotions can and do sometimes overtake logical thought or action. All the education we layer on a child will not make a difference if the key adults in his life are not there emotionally. The five most important words you can say to him: “I am here for you.” In the midst of all that doing for him, make time for just being with him. ◀

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*Three-time ForeWord Book of the Year finalist Ellen Notbohm is author of one of the autism community’s most beloved books, Ten Things Every Child with Autism Wishes You Knew, and three other award-winning books on autism. To contact Ellen or explore her work, visit [www.ellennotbohm.com](http://www.ellennotbohm.com) or on Facebook at Ellen Notbohm, Author.*



# Misconceptions About School-Related Homicides

By Dr. Peter Langman

In the last fifteen years, a number of large-scale attacks at schools have made the issue of school violence a prominent concern across the United States. Despite the massive attention focused on this issue, there are widespread misconceptions about school violence.

## Frequency of Homicides at School

Perhaps the biggest misconception is that school shootings and other types of school-related homicides are common events and/or increasing in frequency. The reality is much different. According to Dr. Dewey Cornell, in his book *School Violence: Fears Versus Facts*, “the average school can expect a student-perpetrated homicide about once every 13,870 years.” In other words, most schools will not have a homicide within our lifetimes, or for many lifetimes to come.

The peak academic year for school homicides was 1992-1993. Since then, the rate has decreased significantly. The Youth Violence Project at the University of Virginia recorded 42 homicides on school grounds in 1992-1993. In the ten years from 2000 through 2009, the average was 6.3 deaths — a dramatic reduction. And, in both 2008 and 2009, there was only one homicide on school grounds each year.

What accounts for this decline? It is impossible to say for sure, but it is noteworthy that the turning point in the homicide rate occurred between the years 1999 and 2000. From 1992 to 1999, the school homicide rate averaged 30 deaths per year. From 2000 to 2009, it averaged 6 deaths per year. Perhaps this reflects the impact of the attack at Columbine High School that occurred on April 20, 1999. Although there had been large-scale rampage attacks at schools prior to Columbine, it was this attack that really made school safety a prominent national concern.

If this hypothesis is correct, it suggests that schools’ efforts to increase safety made a difference. Or perhaps students became more sensitive to warning signs of violence and started reporting their

concerns to parents, teachers, counselors or administrators. Whatever the reason, the data clearly indicate that school-related homicides have become very rare events. On average, school is the safest place children can be.

It is hoped that the current economic climate does not result in reduced funding for schools. Budget cuts could potentially result in an increased risk of violence. Cuts to faculty, counselors, security officers and others might adversely affect the ability of schools to maintain the level of safety that has been established.

## Who Commits School Shootings and Why?

Certainly, school homicides can take many forms including beatings, stabbings and shootings, but it is rampage school shootings that have received an overwhelming amount of attention. These attacks involve a student going to his own school and opening fire — generally at random people. Who commits such an act? Initially, researchers focused on identifying a profile of rampage school shooters. This effort, however, missed the fact that school shooters are not a homogeneous group.

Nonetheless, there are common misconceptions about school shooters. People often think school shooters are loners, victims of terrible mistreatment and detached from their schools and communities. It is also commonly thought that school shootings are acts of retaliation against specific people who tormented the shooters. In most

cases, however, school shooters do not fit this description.

In almost every case, school shooters have friends. In most cases, they are not victims of bullying. They are often involved in activities at school and in the community. And they rarely target anyone who picked on them. So who are school shooters?

As explained in my book, *Why Kids Kill: Inside the Minds of School Shooters*, the perpetrators of rampage school attacks fall into three categories.

- **Psychopathic shooters.** These are youths who are narcissistic and sadistic. They have deficits in the ability to experience empathy, guilt and remorse. They reject traditional values and morality and meet their own needs at the expense of others.
- **Psychotic school shooters.** These youths experience hallucinations and delusions. The most common type of delusion can be described as paranoid, although some of them also have delusions of grandeur. In addition to hallucinations and delusions, these youths have significant social and emotional deficits.
- **Traumatized shooters.** Whereas the psychopathic and psychotic shooters come from intact families with well-functioning parents, the traumatized shooters come from broken homes and dysfunctional families. They have parents with criminal histories. They have parents who abuse drugs and alcohol. These youths are victims of emotional abuse, physical abuse and sometimes sexual abuse. They bounce around from one relative's home to another, sometimes ending up in multiple foster homes. Their lives are unstable and unsafe year after year, and eventually they reach the breaking point.

The fact that someone is psychopathic, psychotic or traumatized, however, does not mean he is destined to be a killer. In fact, most people in these three categories are not violent. The categories help us to understand the types of youth who commit school shootings, but the categories are not complete explanations. There are always other factors involved that shape the behavior of the perpetrators.

But if the attacks are not retaliation against bullies, what is the motivation? Motivations vary across shooters and, even within one shooter, there can be multiple factors driving him to murder. Sometimes shooters are seeking fame and to establish powerful identities for themselves. They may be lashing out at the world, unleashing pent-up rage and frustration. They may attack the students they envy — those kids who seem to have everything going for them. The shooters may be paranoid and believe their lives are in danger; thus, they lash out at others in an act that they conceive of as self-defense. They may hear voices telling them to kill people. Occasionally, there is a specific target, but this is not necessarily a bully. It is perhaps more likely to be a girl who rejected the shooter or a principal who symbolically represents the school.

#### What works in prevention?

When people think about preventing school shootings, they often think in terms of physical security measures: ID badges, video cameras, metal detectors and so on. Though these measures serve a variety of purposes, they do not stop school shootings. Rampage attacks have occurred at schools with metal detectors and even armed security guards. By the time a student enters a building, armed and willing to die, physical security measures will not stop the attack.

Similarly, lockdown drills may help to minimize casualties during an attack, but they do not prevent an attack.

What can be done then to prevent school shootings or other school-related homicides? The best approach is to focus on educating students on the warning signs of violence. It is, of course, important to educate faculty and staff as well, but students are really the eyes and ears of a school. If someone is planning a violent attack, other students are most likely the ones who will know about it. If they are trained in what to look for and how to report their concerns, school shootings can be stopped entirely. In fact, the majority of foiled attacks have been stopped because students came forward with what they knew. ◀



*Dr. Langman has worked with children and adolescents for over twenty years. He spent 12 years at KidsPeace and now consults to the organization.*

*Dr. Langman's book, Why Kids Kill: Inside the Minds*

*of School Shooters, was named an Outstanding Academic Title of 2009 by the American Library Association. It has been translated into German and Finnish and is forthcoming in Dutch. He has been interviewed over one hundred times by media outlets in the United States, Canada, Europe, Australia and the Middle East. He has appeared on CBS-TV, CNN, Fox and the BBC. His research on school shooters has been featured in articles carried by The New York Times, The Washington Post, The Los Angeles Times, Forbes, USA Today, Education Week, Junior Scholastic, MSNBC, Yahoo News, and thousands of other news outlets. Dr. Langman writes a blog for Psychology Today. His research on school shooters has been cited in congressional testimony on Capitol Hill. His website is [www.schoolshooters.info](http://www.schoolshooters.info). Dr. Langman received his B.A. in psychology from Clark University, his M.A. in counseling psychology from Lesley College, and his Ph.D. in counseling psychology from Lehigh University. In addition to being a psychologist, Dr. Langman is a poet and playwright.*

**The peak academic year for school homicides was 1992–1993. Since then, the rate has decreased significantly.**

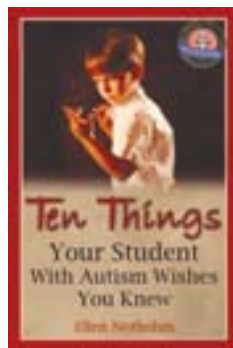
In this issue of *Healing Magazine*, we are publishing reviews of two of our favorite books. At *Healing*, we're always looking for new resources and information that would be useful to those who care for, treat and teach kids. If you have a suggestion, please send it to:

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## Ten Things Your Student with Autism Wishes You Knew

By Ellen Notbohm



Ellen Notbohm has an amazing gift for explaining the most complicated aspects of interacting with autistic children in simple language that resonates with truth, clarity and enlightenment. This book is written in the voice of a child and is for all those who teach autistic children in the classroom, in the home and in other areas of their lives. Notbohm explains that autistic children think in concrete terms and are visual learners – they don't understand questions like "do you have ants in your pants?" to mean anything other than the questioner thinks that there may be insects in their trousers.

Notbohm stresses that it takes a team effort to teach an autistic child, including the classroom teacher, speech and occupational therapists, para-educators who help the child in the classroom and, most importantly, the family. Communication is imperative on a daily basis. There are teachers who refuse to make any accommodations for different learning needs, and this is unfortunate not only for the autistic child but for all children in the class and the teacher as well. Notbohm compares autistic children to other children in their classes as PCs and MACs – neither is "wrong," they are merely wired differently, and being able to operate one does not guarantee one's ability to operate the other. She points out that teachers and parents should approach each other with blank slates at the beginning of the school year and open lines of communication with positive expectations and cooperative attitudes.

Most children with an autism spectrum disorder find it difficult to multi-task and may also have difficulty categorizing or comprehending cause and effect. She explains to teachers that trust is the foundation of learning for a child with ASD, and it is important to always remember that they have feelings that can be hurt as badly as any other child's by a mean comment or mocking attitude. She also encourages teachers to cultivate curiosity, sometimes using the areas in which the child has an interest, even if it is not part of the general curriculum. Ultimately, teachers and families want the same thing for children with ASD: For them to move forward, become independent and gain self-sufficiency. – *PS*

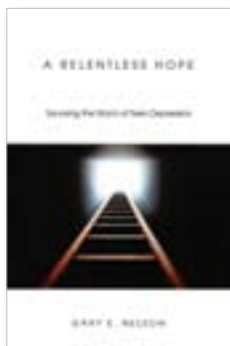
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## A Relentless Hope: Surviving the storm of teen depression

By Gary E. Nelson



Gary Nelson chronicles his son's fight against depression and how they joined together as a family to bring Tom back. Gary is a minister turned pastoral counselor who provides interfaith counseling to youth with problems very much like his son's, which makes the situation even more poignant as one reads about Tom's slide downward into a depression that nearly took the young man's life. Gary wrote this wonderful book for teens, parents, teachers, counselors and pastors in hopes of teaching them the signs and how to help them bring other youth from the brink of deep, deep depression.

Tom had been a normal kid who played baseball very well and had many friends. Around the time he entered high school, he started pulling away from the friends and activities he had previously loved and began feeling "sick" and unable to attend school. He spent more and more time in his room and literally days in bed, and he would have fits of rage during which he would throw things into his walls and ceiling, one day almost shattering his bedroom door. He left the baseball team in anger over criticism by the coach and withdrew from all of his friends. Eventually he came to realize that something was wrong, but he had no control over it. He described it to his parents as "feeling like he was being beaten from the inside." His sleep patterns changed, he was irritable and angry a lot of the time and was unable to focus on schoolwork, sports or relationships with his friends and family. It was perhaps harder for Gary to watch considering that he was a counselor himself yet unable to reach his own son. Gary also became very concerned that Tom may turn to suicide to stop the pain he was experiencing.

He makes the point that parents need to work "with" their depressed children rather than trying to "fight it" with anger and recriminations. Gary strongly suggests asking your children if you can help them develop a plan for getting through it but not trying to pressure them into feeling better because they have no control over it and feel like greater failures if they cannot meet parent expectations. He also suggests trying to get them into counseling but making sure that you find someone to whom your child can relate and talk. In some cases, medication can help, but that is a big decision that must be made on an individual basis.

Gary and his wife were willing to try some creative and even risky ways of helping Tom fight his depression and accompanying anxiety, allowing him to start working at a young age and getting his GED rather than finishing a high school he just could not make himself attend. They bought him a car and encouraged his interest in music, even heavy metal if it made him feel that someone understood his pain.

There are so many strong and hopeful messages in this book to help families get through a child's depression in tact, still spending quality time with other children and not allowing this illness to ruin a marriage. Tom is married and doing very well as an adult now, and Gary even describes the wedding that was moved at the last minute due to hurricanes. This wonderful book speaks of faith and love and hope and a family's decisions to fight to help their child no matter what it took. It is an inspiration and well worth reading if you have any contact youth who are debilitated by depression.

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