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Volume 4, No. 1

Giving kids
confidence
to overcome
crisis

Practical, clinical information



KidsPeace®
The National Center for Kids Overcoming Crisis



**KidsPeace National
Centers for Kids in Crisis®**



**National Hospital
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Healing™

MAGAZINE

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COVER PHOTO:

Who says brothers and sisters don't get along? Alexander Jakob gets a kiss from little sister Sunny Rae Greenberg after spending a sunshine-and-sliding board afternoon at the local park.



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About KidsPeace

KidsPeace is a private, not-for-profit organization dedicated to serving the critical needs of children and teens. Since 1882, KidsPeace has been helping kids develop the confidence and skills to overcome crisis in their lives. Today, KidsPeace offers a comprehensive range of treatment programs along with educational services to help families help kids anticipate and avoid crisis whenever possible. Recognized for its exemplary work with children and families, KidsPeace is the recipient of "Accreditation With Commendation" from the Joint Commission on Accreditation of Healthcare Organizations and "The Outstanding Organization Award" from The American Association of Psychiatric Services for Children.



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HEALING MAGAZINE

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Keep those cards and letters coming..



John P. Peter
*KidsPeace President
and CEO*

As we move into our fourth year of producing “Healing Magazine,” I am pleased to report that our readers are providing more and more input on what KidsPeace can do to make the magazine work better for you. You’ll find some of your suggestions in this issue...

- Articles on tough topics, such as teen suicide and depression.
- Features on innovative therapies that can help kids learn new coping skills and grow.
- Information for the parents of special needs children.

News about KidsPeace’s study of how 13- to 15-year-olds are coping with today’s social pressures and about how kids, parents and professionals are responding to some of KidsPeace’s free special services is scattered throughout the publication. You’ll also see your favorite regular columns: “KidsArt” and “The Family Resource File.”

I especially want to call your attention to a story introducing the new KidsPeace Model of Care. This extraordinary standard for the treatment of kids in crisis is meaningful not only for us as an organization, but also for the greater world community of children’s professionals. It even has an application for parents and other concerned adults. The article tells how we created the model, and what it could mean for you and the kids you care for, teach, love.

As they say, keep those cards and letters coming. When we help you, we help give kids the confidence and skills to overcome crisis. And that’s what KidsPeace is all about.

For the Kids,

John P. Peter
President and CEO

The new KidsPeace Model of Care:

a universal archetype for the
treatment of kids in crisis



By Susan Gottshall Brandell

From the 300-acre mountain orchard campus of KidsPeace, The National Center for Kids Overcoming Crisis, the view is of eastern Pennsylvanian hillsides rolling across the horizon like waves without their white water. Small towns, sprawling housing developments, farms and pastures dot the picturesque panorama. On the campus itself – with new, modern buildings and impeccably manicured grounds – there’s a sense of order, strength and serenity.

For kids in crisis, it is a safe harbor of care and caring.

Here, hundreds of beds in KidsPeace’s residential programs are close to full most of the time, as are the 72 beds at the National Hospital for Kids in Crisis.

And beyond the limits of the Orefield campus, the help and healing continue.

Every day, KidsPeace provides services for nearly 2,000 children and adolescents in programs ranging from therapeutic foster care to inpatient psychiatric treatment. Operations in Georgia, Indiana, Maine, Minnesota, New Jersey, New York and Pennsylvania are supplemented with care provided by KidsPeace-screened practitioners in the organization’s National Affiliates Network, an entity that spans America.

Richard Biolsi, KidsPeace executive vice president for programs, says the social pressures on kids are growing greater and greater. Drugs, gangs and fractured families are just a handful of them. But, he says, those pressures are not the only symptoms of the changing times. “We see crisis in younger and younger kids,” he notes.

Early in the decade, KidsPeace also saw a 150-percent increase in the number of kids coming for help.

What more could the organization do? KidsPeace President and CEO John P. Peter wanted to find out, so he issued a mandate for the development of a new treatment model – one that would help give kids confidence to overcome crises, both those immediately impacting the child and those that would inevitably occur in the future. Supported by the Board of Directors, he called together a task force about a year ago to embark upon an extraordinary course of deliberation and discovery.

“Ideology put into action”

What resulted is the “KidsPeace Model of Care,” a 24-page document outlining the beliefs and practices that form the foundation of the organization’s care and treatment of children, youth and

families. But most important, it describes a process for change that will enable kids to take the tools of healing with them on their life journeys, rather than leaving them at the doors of KidsPeace.

Building on the existing KidsPeace platform, the new model is the framework ensuring that the organization's core beliefs drive every aspect of kids' day-to-day experiences.

Biolsi describes the model as "ideology put into action."

Six categories – dignity, safety, relationships and belonging, empowerment, character and transformation – are translated into the core belief statements upon which KidsPeace stands. To turn these beliefs into practice, the task force developed a principle statement for each, along with a clear and detailed outline of roles for which kids, staff and the organization and its programs must take responsibility to assure the model's assimilation, implementation and ultimate success.

Each principle statement has three parts:

1. An affirmation – restating the core belief – that begins with "I believe," indicating a cognitive conviction.
2. An authentication – declaring an internal response to the belief – that begins with "since," indicating the emotional and spiritual process of owning the belief.
3. A promise of action – confirming the "living out" of the belief in work and practice – that begins with "therefore," indicating motivation and commitment to physical action.

It is that action that makes the Model of Care a living document. And the singular standard for putting core beliefs into day-to-day practice. As such, it is meant to keep KidsPeace on track toward its mission of giving kids the confidence and skills to overcome crisis.

"What it all really boils down to is change," says KidsPeace President and CEO John P. Peter. "Taking the time to help young people change the way they think, feel and act."

That's what transformation is all about. And that's what KidsPeace is all about.

Building on kids' strengths

When task force members began their work, Biolsi says, they knew they wanted to look beyond programs, beyond treatment plans, to figure out what it would take to give each kid the best chance for accomplishing long-term change.

"The time we have with these kids is really so short," he says. "We must take the best advantage of that brief period so that they have their best chance to grow and be successful in the future after they leave us."

In the KidsPeace Model of Care, it's the development of resiliency – a combination of purpose, courage and skill – that gives kids their best chance for accomplishing life change. When kids find hope in possibilities, when they persevere in the face of obstacles, when they know how to use problem-solving skills that create self-empowerment... Then, they have the resilience to withstand and overcome adversity.

The transformation process creates confidence. Resiliency reinforces it.

As Peter puts it, "Peace for kids is not the absence of conflict, but the confidence to overcome it."

Resiliency is the cornerstone of the Model of Care. This important concept sets the KidsPeace approach to kids apart from other treatment programs. But the new model's uniqueness doesn't stop there.

Biolsi, who headed up the task force, says members knew from the start it



Purpose + Courage + Skill

Time = **Resiliency**

should be kid-centered, peer-related and strength-based. Clearly, the needs and hopes of kids come first in this model, in which they are central to all programs and organizational life. The model also recognizes the importance of kids' relationships with each other as another piece in the puzzle of healing, and growth toward independent and successful living.

While some treatment programs concentrate only on "fixing what's wrong," KidsPeace emphasizes identifying kids' strengths and building on them, whether they are academic, athletic, artistic or otherwise.

"These kids have many strengths," Biolsi says. "The fact that they have come this far proves that." In the

KidsPeace approach, changing negative behavior goes hand-in-hand with opportunities for experiences that strengthen positive behaviors and empower competence development.

Bringing beliefs, language and action into alignment

The Model of Care is an organization-wide standard – a set of guiding principles for staff, volunteers, management and kids at KidsPeace locations everywhere. Formally introduced to supervisors and managers in September 1998, the model was in its roll-out stage of staff education and training when this publication went to press. But, Biolsi says, "This is not something you can teach in a classroom. You have to struggle with it and discuss it."

Biolsi predicts it will take a year for the model to be fully implemented throughout the organization "because it's not enough for staff to know the principles. They have to feel them and let them guide their actions." Most KidsPeace caregivers, he believes, are already personally motivated by these principles; they may not, however, consciously assess program elements with them in mind. The implementation will bring beliefs, language and action into alignment to create nothing less than a universal archetype for the treatment of kids in crisis.

An analysis instrument is being developed to measure how programs carry out the model's principles. With it, every program can evaluate its policies,

Dignity

"I believe that every kid is unique, and has dignity and value. I believe that every kid has inherent worth and should be unconditionally nurtured, respected and honored as a human being.

"Since every person is uniquely valuable, I desire to treat each kid as I want to be valued myself – as an individual with a unique story who desires to be understood, respected and accepted. I seek to understand kids' needs, and respect individuality. I desire to avoid making assumptions or taking actions solely upon symptoms, behaviors or words.

"Therefore, I commit myself to nurture, honor and value the kid at all times; to respect kids in my words and in my actions; to seek to discover, understand and treat fundamental solutions to problems; and to look for, encourage and celebrate the good in every kid."

Safety

"I believe that safety is a primary need and fundamental right of every kid. I believe every kid should be safe from physical, emotional and sexual abuse, harm and neglect. I believe a kid deserves a physically safe and emotionally nurturing environment to learn, play and grow in.

"Since physical safety is a primary need of kids, I desire to protect kids from harm – to protect their bodies, to safeguard their personal property and to respect their privacy.

"Therefore, I commit myself to fostering a healthy, safe relationship with and environment for kids. I commit myself to intervening positively and safely when dangerous and threatening behaviors occur."

Relationships and belonging

"I believe that kids grow in the context of supportive relationships. I believe the desire to belong is a powerful motivation for change, so kids are helped most by people closest to them. I believe that acceptance, safety and trust are key to healthy change; when lacking, growth is inhibited. I believe giving to and receiving from a group is essential for kids to grow. I believe in the positive influence of peers and adults.

"Since kids change in the context of supportive relationships, I respect kids' need to belong and seek to foster positive relationships. I seek to guide and facilitate growth and change by providing a nurturing environment. I desire to respect cultural, religious and ethnic diversity while building acceptance and community.

"Therefore, I commit myself to understanding and advocating for positive peer relationships. I commit myself to fostering collaboration, and finding and linking kids with others who will strengthen and encourage growth. I will nurture an environment that recognizes and values the influence of positive peer relationships."

programming, supervision, interactions between kids and staff, treatment planning and other activities. In this way, the Model of Care works as a tool that KidsPeace can use to change practices that diverge from the standard. Future programs will be assessed against the model before they are put in place.

Developed by staff professionals from all KidsPeace programs, the Model of Care is grounded in both theory and practical experience. Social workers, child care counselors and other mental health professionals studied and visited other programs, and listened to what experts had to say about treating kids in crisis. Dr. Larry Brendtro of the Black Hills Seminars, Andrew Schneider-Munoz of Harvard University, Dr. Howard Polsky of

Columbia University and Lorraine Fox, child care consultant and trainer, were among those to share their views.

Each time task force members came together, they discussed, argued, brainstormed and dreamed about how the model could best serve kids. Ultimately, the KidsPeace Model of Care would become a synthesis of everything they already knew and everything they would learn. In synergy, it would surpass it all.

Says Biolsi, "This approach, we believe, is the best approach to helping kids make long-term transformation that will lead to successful lives. And it's the best value for treatment we can provide. The Model of Care ensures that."

Many treatment programs for kids have a mission statement or goal statement, but, Biolsi says, "This is the most all-encompassing expression of care principles that I have seen."

And the Model of Care's breakthrough thinking puts KidsPeace one step closer to realizing its vision – to turn a generation of kids in crisis into a nation of kids who overcome.

Details about the roles KidsPeace, the kids in care, staff and programs will play in the implementation of the new Model of Care will be explored in upcoming issues of "Healing Magazine." Questions about the model can be directed to Richard Biolsi at (610) 799-8071.

Empowerment

"I believe that every kid has powerful potential. I believe that every kid has strengths that provide potential to change his or her life for the better. I believe in fostering courage to overcome obstacles and to uncover latent or hidden strengths. I believe that empowering kids creates fundamental change.

"Since every kid has powerful potential, I desire to help kids recognize strengths, master skills and visualize the best; envision and act upon their future more than the present or past. My ambition is to emphasize positive potentiality while helping kids to deal with negative reality. I desire to learn more about my profession, my specialty and myself.

"Therefore, I commit myself to ongoing study and learning challenges designed to sharpen skills, give me new tools and improve my performance. I commit myself to empowering kids to discover, trust and utilize their strengths and master their skills. I will be positive with kids at all times, even when correcting. I will trust and affirm their potential, offering opportunities for them to exercise their unique talents, boost their confidence and experience positive change, however small, so they can see in themselves what they already are."

Character

"I believe that kids learn by making decisions and taking actions based upon values. I believe that character requires the ability to make reasoned decisions about values. I believe authentic character is the courage to act consistently with personal beliefs while respecting others: to tell the truth, to keep promises and to act with genuine compassion and integrity toward others.

"Since kids learn by making decisions and taking actions based on values, I desire to encourage kids to discover and integrate values. I desire to mentor or form intentional relationships with kids that allow me to ask pertinent questions, listen without judgment and be ready to help. I desire to speak truth, keep promises and act with genuine compassion. I seek to help kids understand how attitudes and values guide behavior.

"Therefore, I commit myself to living with integrity and holding myself accountable to KidsPeace's shared values. I commit myself to integrating values with actions. I commit myself to practicing unconditional acceptance, generosity, truth telling and promise keeping, and encouraging the same in kids."

Transformation

"I believe that transformation is a process of discovering strengths through choice, risk, failure, insight and success. I believe that transformation is a complex, inside-out process (intellectual, physical, emotional and spiritual). I believe that learning positive ways to overcome a present crisis builds strength, courage and confidence to successfully overcome future crises.

"Since transformation is a process of discovering strengths, I seek to turn negative experiences into opportunities for positive growth; to engage strengths through responsible action more than obedience; to seek collaboration more than control; to emphasize values more than behavior; and to embrace reflective problem solving more than rote knowledge. Since transformation advances through many steps over time, I desire to be patient, positive and affirming to kids throughout the process.

"Therefore, I commit myself to fostering inside-out change in empowering kids by encouraging strengths and interdependent skills, and granting freedom to fail and succeed safely. I commit myself to believing in kids' potential, to positive affirmation, and to continuous learning through life space intervention, utilizing teachable moments for growth. I commit myself to a holistic view of treatment – renewing spirit, mind and action."

Why young teens whistle:

KidsPeace survey examines confidence level, fears, resources of 13- to 15-year-olds

By Jim Van Yperen
KidsPeace Advancement

*Henry David Thoreau once gave this advice:
“When a dog runs at you, whistle for him.”*



In the past several years, the number and size of “canines” – in this case, social pressures – running at teens have increased dramatically. Teens today face greater problems at earlier ages than ever before. At the same time, America’s teens show remarkable confidence in their ability to solve and overcome problems.

Teens have learned how to whistle.

We call it resilience – the purpose, courage and skill to overcome crisis. We see it daily in our homes, schools and treatment centers. Teens are remarkably resilient. But why?

During the past year, KidsPeace set out to examine resilience in young teens – i.e., adolescents aged 13 to 15. The organization uses this and other research data to build awareness through educational media and to refine strategies for care at the National Hospital for Kids in Crisis and KidsPeace National Centers for Kids in Crisis, the KidsPeace treatment divisions. Specifically, the organization wanted to know:

- How confident do young teens feel about handling crises?
- What do young teens fear about the future?
- Whom do young teens turn to for help?

A study was designed to understand how young teens identify and respond to crisis situations. To become well-acquainted with the life and mind of the teen, the research was conducted in two phases.

The initial phase was a qualitative study among 13- to 15-year-olds. In this phase, KidsPeace conducted personal interviews with 27 young people, asking them a variety of open-ended questions. This research helped identify the crises, resources and concerns of young people, which better enabled the organization to develop the quantitative research process.

The second phase of this project was a large-scale quantitative survey among 1,066 teens in the 13- to 15-year range. These interviews were conducted by telephone with a nationwide random sample. Upon completion of all the interviews, the data was weighted to provide a proper distribution, based upon current Census Bureau estimates.

Here is what the “KidsPeace 1998 Early Teen Survey” found: Young teens are positive, future-driven problem solvers.

Young teens are positive about the present

Young teens express clear satisfaction with their lives.

Eighty-three percent of the teens surveyed said that they were “completely” or “mostly” satisfied with life.

Twenty-seven percent said that they were “completely satisfied,” and 56 percent claimed that they were “mostly satisfied” with life.

One out of seven (15 percent) described themselves as “somewhat satisfied” and “somewhat dissatisfied” at the same time. Only one percent of teens

said that they were “mostly dissatisfied” with the way things were going for them. The remaining one percent said that they were “completely dissatisfied” with life. (Table 1)

Several trends emerged from the data:

- The younger the teen, the more likely that the teen was to say that he/she was “satisfied” with life: 27 percent of 13-year-olds, 24 percent of 14-year-olds and 21 percent of 15-year-olds claimed to be “completely satisfied” with life.
- Teens living with both birth parents were 51 percent more likely than those living with just one of their birth parents to be “completely satisfied” with their current lives (25 percent vs. 17 percent).
- There is a clear division between the 13- to 14-year-old age group and the 15-year-olds. The 15-year-olds were much less likely to express life satisfaction (76 percent “completely” or “mostly” satisfied) than were the 13-year-olds and 14-year-olds (84 percent). This finding may be related to grade level since those in the eighth grade also were revealed to be much more likely than those in upper grades to be “completely satisfied” (29 percent vs. 21 percent). It may reflect the fact that most eighth graders are the oldest kids in their schools, while most ninth and tenth graders are on the bottom rungs of the high school seniority ladder.
- Academic performance is linked with life satisfaction. One quarter (25 percent) of those whose grade point average was in the “C or lower” range were “not completely” or “mostly” satisfied with life, compared to 16 percent of those in the “A” or “B” grade ranges.

Table 1

Young teens’ satisfaction with life

58%	mostly satisfied
24%	completely satisfied
16%	somewhat satisfied/ dissatisfied
2%	mostly dissatisfied

Copyright 1998. From the “KidsPeace 1998 Early Teen Survey.”

America's young teens are confident. Half of all the 13- to 15-year-olds surveyed described themselves as "well-liked," "happy" and "self-confident."

This confidence shows itself in the ability to meet and handle life's challenges, despite evidence that most teens had already faced considerable life challenges. Seventy percent of the teens surveyed had already experienced the death of a family member or close friend; 43 percent said that they had felt very lonely in life; 38 percent said that they had experienced extreme stress and anxiety; and 17 percent, that they had lived through divorce.

At the same time, it might be argued that teens are not always aware of the full impact or implications of the crises that they experience. Experiencing the divorce of their parents may serve as an example.

Nineteen percent of respondents said that, at the time of the survey, they were living with one of their birth parents. Yet, only three percent recognized their parents' divorce as an actual crisis. Other research studies have demonstrated that the effects of divorce can be devastating for the immediate and long-term development of the children in the household. However, teens, in general, did not identify their parents' divorce as a crisis.

How can teens miss the emotional impact of divorce that so many others have felt? The likely answer is that in teens' resilience and independence, and in their efforts to survive, succeed and grow whole, they are unaware of the negative impact that such an event could have on their own development or emotional well-being.

Parents and caregivers will help young teens with open and honest conversations about what is really harmful. Teens may be so positive about the present that they are blind to real danger, but they are a thoughtful group of people who will listen to those who will listen to them – especially about what threatens their focus on the future.

Young teens are focused on the future

The transition from childhood to adulthood is in full swing by 15 years of age. Caught between childhood and adulthood, young teens are thinking about what they want to do with their lives, and the kind of lives that they want to lead. These life-shaping decisions about the future consume young teen concerns.

When it comes to the future, most young teens aspire to very traditional

Why are kids so confident? One answer may be in teen language. Significantly, the word "crisis" seems not to appear in the teen lexicon. Despite having already experienced significant, crisis-like events in their lives, most youths did not expect to deal with many crises over the next three years.

Is this optimism, denial or well-balanced perspective? Seemingly, a past encounter with crisis is not as emotionally jarring as adults might assume. So many of the teens surveyed appeared not to be fazed by the prospect of facing the situation again sometime soon.

It could be argued that many teens don't want to admit that they will have to face further crises in the future. They may expect to experience difficulties. But with the increased independence that their teen years and their own emerging individuality allow, they may not want to acknowledge that situations in the next three years could get the best of them.

Table 2

Young teens' hopes for the future

- 59% go to college/get a college education
- 44% employment at enjoyable job
- 40% have a family, children
- 34% have a well-paying job
- 10% marriage
- 9% reach career goals
- 6% financial security, money
- 6% happiness
- 5% buy/own a home
- 4% reaching goal in sports
- 3% graduate from high school
- 3% fame
- 7% don't know

Copyright 1998. From the "KidsPeace 1998 Early Teen Survey."

elements of adult life: to attend college, to marry, to have children, and to take on a well-paying, enjoyable job. (Table 2)

Young teens are apparently focused on “making it” in life. Five of their top seven hopes for the future are achievement- and career-oriented. Four deal specifically with finding a job that brings security, career fulfillment and personal enjoyment. Also near the top of the list are traditional elements of adult life such as marriage and child rearing.

Likewise, the top concerns of young teens are “handling extreme stress and anxiety” (25 percent), the “death of a family member or friend” (24 percent) and “disappointment from not accomplishing goals” (22 percent).

Fears of safety crises such as “being physically or sexually assaulted” and “using or suffering from alcohol or drug abuse” – the primary concerns of many parents – are of relatively little concern to young teens.

While parents, media and leaders of the country are rightly concerned about violence, AIDS, crime and substance abuse, the fact is that these concerns rank at the bottom of the list for teens, themselves. Only one percent of America’s 13- to 15-year-olds are concerned about contracting AIDS; five percent worry about drugs; one percent worry about alcohol abuse; and four percent believe that they will be the victim of a crime.

Instead, making enough money, experiencing employment problems and experiencing a bad marriage or family problems are primary concerns. Young teens feel stressed at the prospect of making it in the future.

Parents and caregivers should recognize that many kids in their early teens are beginning to think through what they want to do with their lives and to consider the kind of lives that they want to lead. Such life-shaping decisions may be the biggest “crises”

that teens identify as “likely” in the years ahead. Assistance regarding furthering their education, choosing a satisfying career and planning for a fulfilling family life might be appreciated by this group, particularly the 15-year-olds.

Young teens are problem solvers

As teens grow older, they are more likely to take responsibility for solving problems into their own hands. Teens want to “make it in life,” and move on after difficult circumstances. They do not fear crises. They want to find their own way out of problems, with the help of peers and parents.

In fact, 65 percent of young teens said that “in the end, the only person you can really count on to resolve a crisis is yourself.” Young teens believe it is up to them to solve their problems.

At the same time, young teens want to be connected. They want empathy and valid advice, and they will take steps to find it wherever they can find people whom they can trust, people who will listen. They need and want to talk honestly and openly with others.

In seeking help with problems, young teens look most to those who they feel listen to them and understand. They said that they are not comfortable discussing serious problems with their parents, particularly parents who provide superficial responses.

The study found that, overall, teens were just as likely to speak with parents as they were to speak with friends if they were to face a significant crisis. Half of the teens (51 percent) surveyed said that they would turn to their parents first. A similar proportion (47

Table 3

Young teens’ first source of advice, by age and gender

Parents	
56%	all
59%	13-year-olds
58%	14-year-olds
50%	15-year-olds
60%	male
51%	female
Friends	
43%	all
41%	13-year-olds
41%	14-year-olds
47%	15-year-olds
40%	male
49%	female

Copyright 1998. From the “KidsPeace 1998 Early Teen Survey.”

percent) maintained that they would initially turn to their friends for help.

Yet, young teens do not feel comfortable discussing serious issues with their parents.

- Nearly one out of three teens (32 percent) claimed that they would be “uncomfortable” having to raise difficult topics with their parents.
- Only two out of 11 (18 percent) said that they would feel “totally comfortable” raising a topic that was very important to them.
- Half of the teens (50 percent) said that they would feel “pretty comfortable” if they had to bring up a matter and talk about it with their parents.

Age and gender play key roles in determining whom a teen talks to about a problem.

- Thirteen-year-olds were more likely to select parents as the first source of help (59 percent), as were 14-year-olds (58 percent). But the percentage drops to half for 15-year-olds (50 percent).
- Boys were much more likely than girls to turn to their parents for guidance, rather than to their friends: 60 percent vs. 51 percent, respectively. (Table 3)

Once a young teen experiences a significant life problem, he or she does not look at life the same. That awareness alters relationships, perspectives and, perhaps, even lifestyles.

- For all 11 possible crises tested, individuals who had experienced a problem also indicated a higher

likelihood of having to deal with a significant life problem again within the coming three years.

- For nine of the 11 crises evaluated, those who had experienced a problem said that they were less likely to seek their parents’ counsel or support with future problems.
- For nine of the 11 crises examined, those who had experienced a problem in the past said that they would be more likely to seek assistance from their peers than from their parents when they encountered a problem in the future. Conversely, among the teens who had never undergone a crisis, the initial source of support would be parents.

The data also suggests that when young teens go to their friends first, it may be as second choice. When teens seek the assistance of friends rather than of parents, it is often because they cannot approach their parents (i.e., “lack of comfort,” “lack of confidence”).

Less than half (43 percent) of the teens surveyed who chose peers as their first source of crisis guidance strongly affirmed that they would trust their friends to provide reliable advice.

Ironically, the issues that parents fear most are those that young teens are least likely to talk to their parents about. Teens are three times more likely to consult friends over parents when the crisis involves “experiencing physical and sexual assault” or “substance abuse.”

The evidence suggests that resilience is strongly linked to parent and peer relationships. When young teens were asked what they would feel if they encountered a major personal crisis and were not able to seek help or support from friends and family, respondents said that the result would be “horrible feelings” (81 percent) and “feeling as if there were no options to pursue” (43 percent). One out of 10 (11 percent) said that they would simply “rely on their inner strength and abilities” to

Table 4

Where young teens turn for help after parents, friends

33%	teacher or principal
22%	minister or priest
9%	guidance counselor
6%	deity
5%	books
20%	no idea

Copyright 1998. From the “KidsPeace 1998 Early Teen Survey.”

cope with the difficulty. Eleven percent said that they “could not even guess” what they would do.

Stripped of their natural allies and source of stability, young teens said that they would most likely turn for help to “a teacher or principal” (33 percent); “a minister or priest” (22 percent); “a guidance counselor” (nine percent); their “deity” (six percent); and “books” (five percent). Twenty percent said that they had “no idea” where they would turn. (Table 4)

Parents and caregivers must be aware that, while many teens are resilient, a confidence gap still exists. In actuality, a trust relationship between parents and teens may be the single greatest predictor of a teen’s future health and confidence. Parents must communicate openly and honestly with teens.

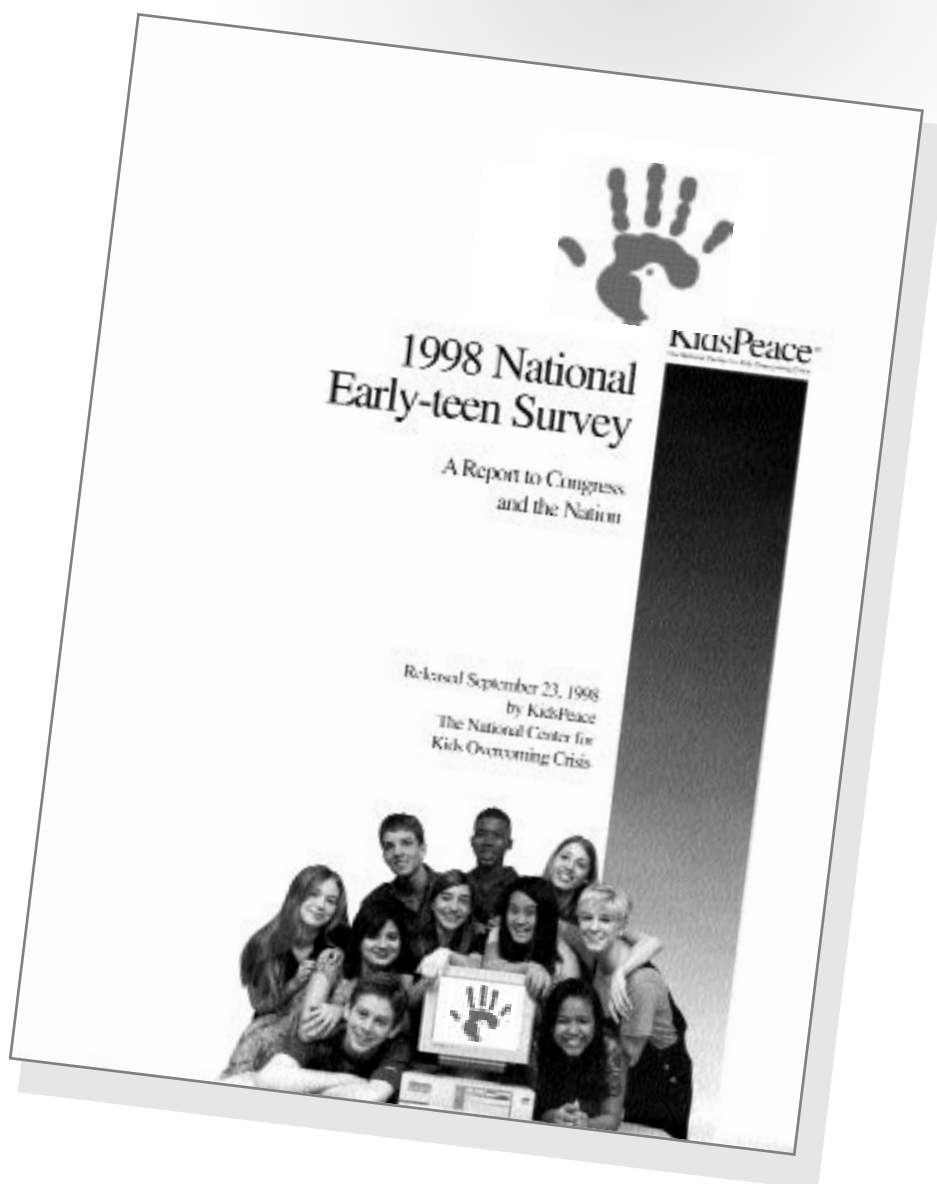
Parents must remove barriers to communication – for example, extreme emphasis on grades – which make teens feel uncomfortable discussing difficult issues with them. It is likely that parents’ honest attempts to help their kids through crisis fail because they do not understand and fail to empathize with what their young teens really need and want.

At the same time, the research found that peer counseling may be a positive influence for young teens in crisis situations. Many teens report that they feel rejected by their parents and isolated in their anxiety. Many more teens trust their friends even more than they trust their parents to give them reliable information. Good friends are probably a tremendous stabilizing factor for teens when it comes to problems such as loneliness, poor grades and stress. Teens may view their peers as better able than their parents to relate to these daily challenges. Thus, they begin to rely more upon the influence of their friends. But teens evidently still need and want to talk with their parents.

For caregivers, one of the more effective interventions for young teens in crisis combines the influence of both friends and family, peers and parents.

Resilience, like whistling, is learned.

For information about the “KidsPeace 1998 Early Teen Survey,” please call the Advancement Department at 1-800-25-PEACE.



The results are in:

“Healing Magazine,” HelpLine and Parenting Kit studies reveal need for resources



By John. R. Hillman Jr.

And that's what

Results from the organization's "Healing Magazine" survey, which ran with a business reply envelope in the Spring/Summer 1998 issue of the publication, have been compiled. The findings were then merged with the results of two additional reports: a 1998 five-month study of calls to the KidsPeace HelpLine, a 24-hour free information and referral service; and, from late 1997 through early 1998, a collection of surveys – again, with business reply envelopes – that were attached to requests for the KidsPeace Parenting Kit. The kit contains the organization's "24 Ways You Can Prevent Child Abuse," "15 Ways to Help Your Kids Through Crisis," "Seven Standards for Effective Parenting" and "Everything Your Preteen Wants You to Know... but May Not Tell You" pamphlets.

While KidsPeace warns that the combined results cannot be construed as a definitive representation of need, the responses received in all three studies seem to indicate a significant demand for information on behavioral and relationship issues.

James Feldman, Ph.D., KidsPeace director of public education, helps to put the answers in perspective.

"The excellent response to the magazine survey is due, in part, to the need for additional information," he

says. "But it's also due to the relevancy of the information

presented in 'Healing,' its delivery, the timeliness, the manner of presentation and the fact that it is practical in a way professionals appreciate. Professionals like the magazine and like the idea of providing input for what they will see in future issues."

The HelpLine, Dr. Feldman notes, is a good barometer for issues that have intensified to a crisis state. The mail-in poll, a fair measure of general familial concerns.

Who said what

The HelpLine records were taken from calls received from children, adolescents, parents and professionals seeking information and advice regarding kid and family problems. The documentation was very generalized and non-specific, a simple tally of call categories rather than a call-by-call survey. The calls predominantly originated within a limited geographic area, northeast Pennsylvania.

The Parenting Kit poll results covered a broader area, capturing responses from across the country. This survey solicited information by category. Additionally, it gathered some demographic detail. Most of the respondents were parents (74 percent) and grandparents. Eighty-seven percent of the respondents were female.

Purpose:

To give kids confidence to overcome crisis.

Question:

What resources will be needed by professionals in the field and the general public to support this mission?

How to obtain the answer:

Ask.

The “Healing” survey was the most explicit, with information request check-off boxes in specific classifications and subclassifications – as well as some optional demographic questions. Responses came either anonymously or from professionals in mental health, education, medicine and juvenile justice – the range of the magazine’s audience. Although originating heavily in the Northeast and Middle-Atlantic States, the publication’s usual distribution area, surveys were mailed from every region of the country.

While some inferences may be made from local results progressing to national, a more directed series of surveys could gather detailed, consistent data to be evaluated for trends and hard numbers. This initial project, however, will serve as a preliminary baseline for formulating future need profiles.

That said, behavioral and relationship issues were a high priority in all three studies.

Behavior problems, aggression, difficulty with handling children and adolescents, and boyfriend/girlfriend woes were the top subjects in calls to the HelpLine. More than half (57 percent) of the Parenting Kit responses focused on building self-esteem, discipline and making friends/peer pressure.

The “Healing” survey logged approximately 87 percent of respondents as requesting articles on child and teen relationships, with child abuse and behavioral issues only slightly less prevalent. The “Child and Teen Relationships” category specified which relationships: with parents, indicated by 31 percent of the respondents; with siblings, by 15 percent; with peers, by 26 percent; with teachers, by 19 percent; and with employers, by seven percent. Requests for articles on abuse also fell into several categories. Thirty percent of the professionals surveyed preferred features on emotional abuse; 19 percent, on physical abuse; 24 percent, on sexual abuse; and 26

percent, on neglect. The range of behavioral issues on which the respondents wanted to see articles written included problems in home, school and community settings; difficulties with baby sitters, social services personnel and law enforcement officials; behavior’s relationship to attention-deficit/hyperactivity disorder; therapy and work-related activities for kids with behavioral issues; aggression; and studies of behavior at malls and other public gathering places.

Requests for information on depression, anxiety and suicide ranked much higher in the “Healing” survey than in the HelpLine study. Almost a third of the “Healing” survey respondents (approximately 30 percent) proposed articles on these topics, while the same topics fell about halfway down the list of HelpLine call categories.

Both the Parenting Kit survey, by its very nature, and the “Healing” survey showed high interest in parenting issues. About half of the “Healing” survey respondents (50.5 percent) expressed the desire to see articles on parenting.

A good percentage of “Healing” readers also wanted specific information on drug and alcohol addictions. In the “Addictions, Other” write-in category, they added “gambling,” “sexual,” “dual diagnosis of addiction coupled with ADHD,” “death and dying,” “stealing,” and “pregnancy.”

General write-in suggestions on the “Healing” survey abounded, as well. In alphabetical order, they are:

- adoption and abandonment, affective disorders, anger, Asperger’s disorder, attachment disorders, bipolar disorders, borderline personality disorders, bullying, conflict resolution, coping skills, cults;
- dating relationships, development, developmental disorders, divorce, eating disorders, grief, homelessness, interracial issues, learning disorders, oppositional defiant disorder;

- panic attacks, peer interaction, phobias, risk-taking behavior, self-mutilation, socialization and its effect on gender relations, spirituality, stress, Tourette’s disorder, violence.

Making sense of it all

According to Dr. Feldman, the emphasis in all the surveys on aggressive behavior and other types of behavioral problems shows significant issues that must be addressed. But determining the specific information that would be most effective in answering this need requires further study.

There are several interpretations for aggressive behavior, Dr. Feldman observes. For example, aggressive behavior in children and youth could be a response to depression.

“We must be careful not to assume that there is only one answer to the findings and miss what is really happening,” he comments.

KidsPeace will continue to strive to deliver information to kids, parents and professionals that could help avert crisis. And to give kids the confidence and skills to overcome crisis when it is unavoidable. This issue of “Healing Magazine” is a part of that effort. Look for articles on depressed and suicidal adolescents, unique therapies for kids, and being the parent of a special needs child. You can help by continuing to let KidsPeace know what you’d like to know more about. Address letters to the “Healing Magazine” editor at KidsPeace, 5100 Tilghman Street, Suite 010, Allentown, PA 18104.

A cause for paws:

Animal-Assisted Therapy extends beyond the “meet and greet” and into the therapist’s office

By Kristin R. Greenberg

*You could say
it's in his blood.*

His mother is a therapist. His father is a therapist. And Brutus – as big at heart as he is in stature, with his calm and inviting demeanor and his soulful brown eyes – continues the family tradition, all the while working toward the advancement and education of his unique modality of healing.

At just six months of age, Brutus was awarded his first good citizen award, the youngest good citizen ever to receive the honor. By 10



Brutus helped me talk and make friends! I know Brutus well

months, he had passed all testing and was hard at work in his career as a certified therapist.

Yet, rather than regale you with stories of his professional accomplishments, Brutus, now a seasoned veteran at five years old, would far rather curl up at your feet and languidly doze off as you gently rub the fur under his belly...

In his work as a certified therapy dog, Brutus has practically seen and heard it all – from the deepest of sorrows, to the greatest of joys. Clients have cried with Brutus, laughed with Brutus, learned with Brutus.

Still, in the face of whatever emotional drama may unfold during one of his sessions, Brutus seemingly remains ever the unwavering professional, treating each client with the same unconditional acceptance and grace.

“Animals offer a very unconditional kind of love,” explains Brutus’ partner, Kathryn Jean Gress, MA, BSN, RNC. In all of her years as a therapist, Gress has never seen one of her therapeutic animals reject a client. “No matter if you’re having a ‘bad hair day,’ if your hair has all fallen out or if you’re not the best groomed you’ve ever been – animals will still accept you.”

It is this nonjudgmental tolerance that animals offer, coupled with spontaneous human-like actions, that provides teachable moments that Gress believes lay the foundation for the success of the rapidly growing field of Animal-Assisted Therapy (AAT). Extending well beyond the traditional “meet and greet” services of Animal-Assisted Activities (AAA), in which certified animals visit hospitals and nursing homes, AAT actively integrates the animal’s presence into a goal-oriented therapeutic setting.



Gress and Brutus have been working together since Gress sought out Brutus as a puppy to work in her private practice, Healing Arts With Natural Therapy. Located in Macungie, Pennsylvania, Healing Arts provides a unique environment of healing that melds traditional modes of therapy with various expressive creative therapies, of which AAT is the central component.

The Healing Arts With Natural Therapy mission is “to increase the quality of life for individuals during their stay in healthcare facilities and/or in outpatient psychotherapy treatment, with a focus on the whole person – the physical, cognitive, emotional and spiritual well-being. The animals serve to motivate individuals in their therapy and bridge communication gaps with the medical staff.”

In addition to her private practice, Gress – a registered medical and

Modeling the many different “hats” of therapy. Kathryn Jean Gress with, from left, Muchka, Ziggafouse and Brutus.

Until he met Gress and joined the Healing Arts team, Sundance was moved in and out of at least 10 different homes in his first four years of life.



psychiatric nurse as well as a therapist – maintains a part-time nursing position at the KidsPeace National Hospital for Kids in Crisis. She takes a keen interest in the link between the mind and the body. In her work as a therapist, Gress combines the mind-body connection with the animal-human bond as the basis for her model of healing. Her philosophy: “Getting to the heart of

matters by utilizing Animal-Assisted Therapy to connect me to hard-to-reach people in a very personalized way that shows care and concern for the people I serve.”

“AAT is not for everybody, and I can respect that,” says Gress, “but, this is how I can best help people.”

Gress has achieved impressive results utilizing AAT for a melange of issues – ranging from autism to eating disorders, anxieties, phobias, depression and most anything in between – in both children and adults. Gress also practices a variety of what she refers to as “creative-expressive therapies” either in conjunction

with, or separate from, her AAT services. Journal writing, movement therapy and art therapy are examples. Sessions are tailored to what modality will best serve each individual client.

In addition to Brutus, a Great Pyrenees, the Healing Arts team includes two felines, Szka Heiya Muchka, or “Muchka,” a blue Persian,

and Sir-Purrs-A-Lot, or “Ziggafouse,” a seal-point Himalayan; two horses, Sundance, a chocolate palomino quarter horse, and Corky, an Arabian; and the newest member of the team, baby Kayla, another Great Pyrenees puppy.

Gress remains a staunch advocate for the animals at all times, and carefully screens potential clients for any allergies, fears or past abusive behavior directed at animals. She educates all clients about the care and handling of animals before introducing them into therapy sessions. Oftentimes, she utilizes stuffed animals for a kind of “practice” run.

The dogs and cats reside with Gress and her husband Ben, who works as office manager, animal handler and – as Kathy fondly refers to him – “therapeutic staff support.” The horses live at Fog Hollow in nearby Maxatawny, a lush, 15-acre farm quietly nestled in the rolling, wooded hills of Eastern Pennsylvania. The farm is owned and operated by Ed Games and Betty Bishop, who, in addition to caring for the horses, breed Great Danes.

All of the Healing Arts animals dress-for-success in tailor-made show-stopping costumes, such as hats bursting with plumage, cowboy outfits or seasonal theme accessories. “The different garb is used for different things,” explains Kathy. “Humor therapy, to help put people at ease, and memory of the seasons or holidays, to remind people there are still things worth celebrating.”

“Animals heal us faster”

Gress believes it is the neotenic, or infantile, juvenile qualities of animals – qualities that evoke the care-taking instincts in humans – that make the animal-human bond such a compelling force.

She first became attuned to the healing powers of animals during her childhood, when she found her love of nature and animals often provided her

with a more relaxed forum to meet people. "I noticed when I was walking with my dog, people talked to me more often than if I were walking alone," explains Gress.

Later, while working as a certified psychiatric nurse, she began spending her days off informally helping troubled neighbors, especially children. "Kids would come over to play with my dogs and my cats, and just start talking to me – about how they felt about whatever was going on in their lives," recalls Gress. "One little girl whose parents were getting a divorce came for a visit. As she was playing with the cats, she just started to open up about how sad, depressed and angry she felt. These were emotions she had not been able to express before. Right then, I knew in my heart that this is my mode, my passion – this is how I'm supposed to help people."

To prove empirically what she instinctively knew to be true, Gress researched pets as mediators of therapy utilizing biofeedback, or electrodermal-response, to measure the emotionality, anxiety and perspiration levels of subjects treated with AAT.

In the study, conducted at Kutztown University, Pennsylvania, Gress observed 20 college students with anxieties about various academic and personal issues. "There is so much subjective evidence about the benefits of AAT; but, because numbers are so important in our society, I wanted to gather the quantitative data," explains Gress.

The results did not disappoint her. "The tests showed these people certainly had anxiety, and when they utilized AAT, that anxiety did decrease. The subjects became significantly more relaxed, experiencing less anxiety and less sweating."

Says Gress, "Animals heal us faster. In a therapeutic setting, they seem to convey the message, 'It'll be okay. This is a safe, secure place. Share what you need to share.'"

Calm in the face of crisis

However, not just any animal can be plunked into a career in therapy. Would-be therapist animals are required to undergo a careful screening process and a battery of tests to prove their aptitude, socialization and obedience – all before even being accepted to train for the job.

"You don't want to put an animal into a setting where he or she is going to get tense," explains Gress. "Therapy animals need to have the ability to remain calm in crisis-oriented situations."

All the animals at Healing Arts have been through a rigorous screening process and have gone through some type of training. However, Brutus, Muchka and Ziggy are currently the only registered therapy animals on staff. Brutus received registration through both Therapy Dogs International and Pet Partners®, a program of Delta Society®, a national nonprofit organization that provides resources and information on service animals, trains volunteers, and screens both volunteers and animals for Animal-Assisted Activities and Therapy.

The Pet Partners screening process is broken down into three distinct components: health screening, to ensure the animal is free of illness, infections, and external and internal parasites; the Pet Partners Skill Test (PPST), to determine whether the handler and the pet have the basic skills needed when visiting people in different places; and the Pet Partners Aptitude Test (PPAT), to determine the handler's and pet's ability to work with strangers.



“Animals who work in therapy need to be more people-oriented than animal-oriented,” explains Gress. “Brutus was specifically selected to become a therapy dog. We researched the breed extensively.”

The Great Pyrenees breed is known for its calm temperament and abilities with children, abilities Brutus puts well to use in his profession. Massive in size, the breed is sometimes referred to as the “gentle giants”: Brutus is considered “skinny,” weighing in at “a mere” 96 pounds.

Healing through horseplay.
At top, Sundance with Nick, Gress, Jackie and Kenneth. Below, Megan and Sundance.



But Brutus’ aptitude, temperament and skill more than make up for anything he may lack in girth. At just six months of age, Brutus was recognized by Therapy Dogs International with a canine good citizenship award, the very first step required before more extensive therapeutic training can begin. Brutus was the youngest Pyrenees ever to receive the award.

And though most dogs are not yet mature enough to begin schooling until sometime after their first birthday, Brutus passed all screening tests at six months and received certification as a therapy dog at only 10 months old.

Kayla, the baby of the group at six months old, will be following in Brutus’ paw prints. She is set to begin testing in the very near future, and already exhibits many of the qualities necessary to succeed as a therapist.

“Brutus helped me talk and make friends”

Brutus’ deft skill as a therapy dog has been recognized on the national level by The Great Pyrenees Club of America. In May of 1996, Brutus received the first national distinguished service award in therapy for his work with a child suffering from a pervasive developmental disorder. Diagnosed with both obsessive-compulsive and attention-deficit disorders in addition to some autism, the child could not communicate well and was exhibiting behaviors that “were traumatic to both herself and her family,” recalls Gress.

In the letter Gress sent to nominate Brutus for the honor, she wrote, “Brutus’...extensive and consistent presence with this little girl...empowered her to initially communicate with him...There is remarkable improvement in this eight-year-old’s ability to develop cognitively, communicate and socialize, first with Brutus, and then...other animals...[and] people.”

The young child was so thankful to Brutus, she wanted to do something

special for him, to help him to “win a ribbon.” In her own painstakingly thought-out words, she expressed her gratitude in a letter: “Brutus helped me talk and make friends! I know Brutus well. I want Brutus to win a prize! I love Brutus!”

It is not just children who find Brutus a consistent source of comfort in times of crisis. Between his enormous size and his ever-present hat, Brutus’ startling appearance has also proved a useful tool for memory and tracking enhancement. Gress recalls working with a woman who was afflicted with vascular dementia: “She was very confused, and had very poor recall – to the point where she often couldn’t remember her husband – but she did remember Brutus. She would say, ‘Oh, that’s Brutus, and he always wears a hat.’ With that connection, she was able to associate others. We were able to bring her back to the present, but it was Brutus she remembered first.”

Muchka and Ziggafouse: teachable moments

The two cats, Muchka and Ziggafouse, were also specifically selected for therapy by breed and temperament. “They are really great cats – they’re really very personable,” says Gress. “We did a lot of training and shaping to get them ready for therapy sessions. We put them out in a lot of different circumstances to make sure they are able to handle unexpected situations.”

“Szka Heiya Muchka” translates from Russian into “the grey-haired lady,” a fitting moniker for the deep-slate-coated feline. At 14 years of age, Muchka has been with Gress the longest. Over the years, Muchka has attained a keen instinct and a quiet resolve that especially enables her to be instrumental in therapy.

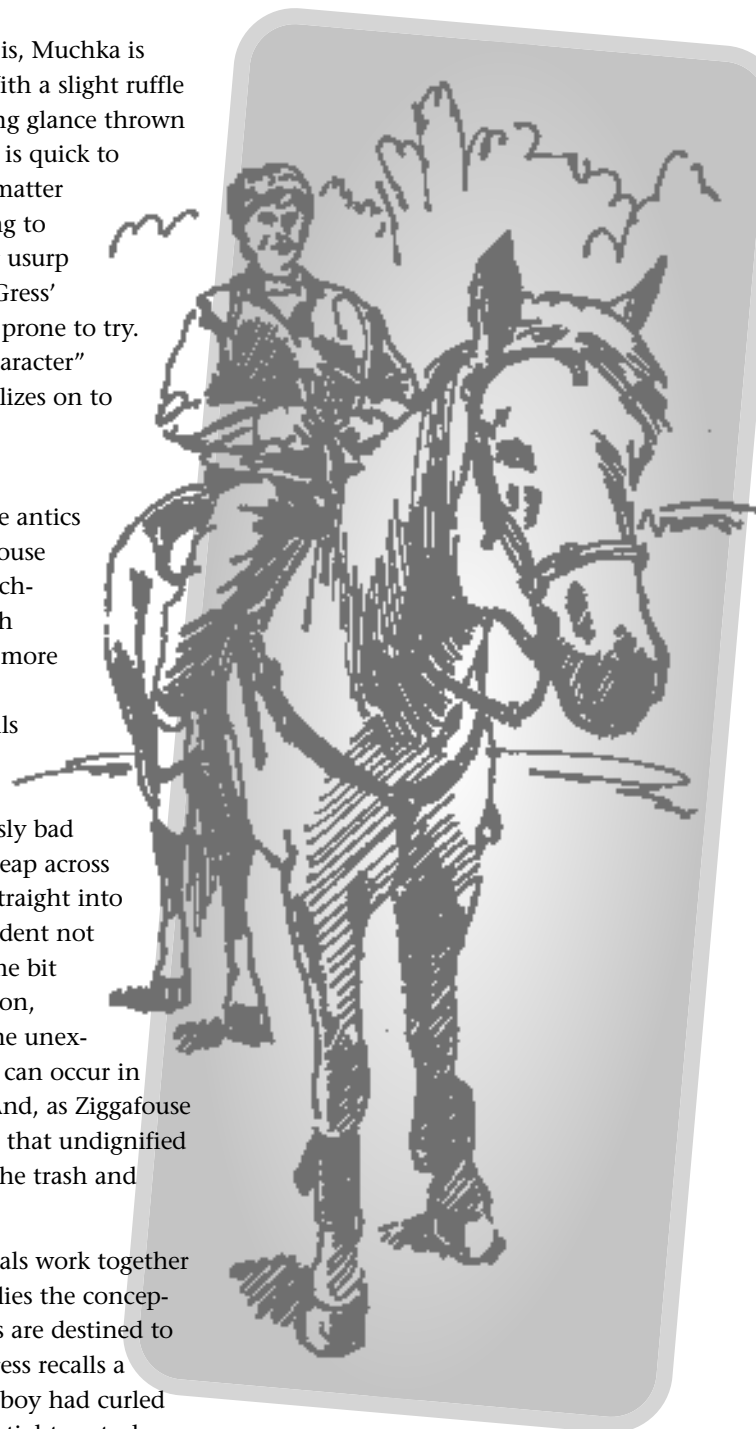
Muchka is often the first animal to greet new clients, and the first to approach when someone is visibly upset. “There’s no direction that I give her, but she just has this sensitivity,”

explains Gress. “Someone will come to the office in a panic attack, and he or she is hyperventilating, and his or her heart is racing. And Muchka could be way over in the corner, but she’ll just go on over and sit by that person, sometimes placing her paw gently on his or her arm as if to say, ‘It’ll be okay.’”

Yet, as sensitive as she is, Muchka is no shrinking violet. With a slight ruffle of her fur and a piercing glance thrown at Ziggafouse, Muchka is quick to demonstrate that, no matter her age, no one is going to get the best of her – or usurp her favorite perch on Gress’ desk – as Ziggafouse is prone to try. It is this display of “character” that Gress often capitalizes on to help clients with assertiveness training.

On the other hand, the antics of four-year-old Ziggafouse oftentimes provide teachable moments in which clients can learn to be more accepting of their own peccadillos. Gress recalls a time during a session when Ziggafouse, a notoriously bad jumper, attempted to leap across the room and soared straight into the trash can. The incident not only brought a welcome bit of laughter to the session, but also exemplified the unexpected difficulties that can occur in any life, at any time. And, as Ziggafouse discovered, it is not all that undignified to dig yourself out of the trash and move on.

In the office, the animals work together with a synergy that belies the conception that cats and dogs are destined to be eternal nemeses. Gress recalls a session when a young boy had curled himself up into such a tight pretzel on the floor that Gress and the child’s mother were concerned about his breathing. Slowly, the animals began



Animals can work with people of all ages. At top, Frieda and Will share a moment with Muchka and Ziggafouse. Below, Brutus takes Kara for a ride while Gress looks on.



to gather around the child. Muchka placed a gentle paw on the boy's arm; Brutus nudged him a bit with his nose. Little by little, the boy's body began to relax, and he began to reach out – first into the welcoming fur of the animals, and then, eventually, to the welcoming ear of Gress.

"We all respect one another," explains Gress. "People will come in and remark about how well all of the animals get along." To translate that spirit of camaraderie to her clients, to teach people to work together and to get along, is primarily what Gress hopes to accomplish.

Not your average horseplay

Yet, successful social interaction is sometimes best learned outside the confines of four office walls. It is then that Gress and her clients travel the winding, tree-lined road to Fog Hollow to spend time with Sundance and Corky.

The horses live on 15 acres of wooded land just far enough removed from the bustle of town life that the delicate sounds of nature alone are often enough to, temporarily at least, quiet the cacophony of internal stress. "Many clients tell me that

being at Fog Hollow with the horses is the most relaxed they've ever felt," says Gress. "Sometimes, I bring particularly anxious clients out here for the environment alone."

Unlike the dogs and cats, Gress' horses were not so much selected specifically for work in hippotherapy (meaning "with the help of a horse") – theirs was

a more serendipitous arrival. Sundance was a malnourished, off-the-track polo pony (starter horse) with leg injuries who had been placed unsuccessfully in at least 10 different homes during the first four years of his life – until his meek and sensitive nature was finally appreciated by Gress. And Corky spent his early years of life crammed into a stall where he couldn't even lift his head past his shoulders, a forgotten birthday gift for a young girl too intimidated by his size to go near him.

Sundance and Corky share their home with several other horses, and it is watching their interaction, especially their non-verbal cues, that affords the opportunity for clients to relate the horses' actions to human tendencies.

"The practice of verbal and non-verbal communication is one of the key factors that is learned through the use of the horse," says Gress.

With his timid disposition, Sundance has a tendency to get pushed around a bit, though according to Gress, he is learning to fight back. "When Sundance sticks up for himself, I try to point that out," says Gress, "to say, 'Look, Sundance was more assertive here, you can be, too.'"

It is Sundance that Gress turns to for therapeutic assistance, particularly for self-esteem boosting. He will receive official certification as a therapy horse as soon as location permits. (Testing is available in limited areas at limited times.) Corky works as an animal activities horse. With a quirky twinkle in each of his one-blue and one-brown eyes, he has brought countless smiles to otherwise somber faces.

Even the everyday caretaking needs of these massive animals – from the simple act of brushing a horse's coat to learning the proper way to "saddle up" to performing ring exercises – provide therapeutic benefits. Gress' clients build stress management skills, enhance the balance of the body and the mind, boost self-confidence and learn about

the responsibilities that are an indelible part of any relationship.

"It's a wonderful thing that Kathy does out here with the horses," says Ed Games. "The therapy is a great thing." Games had his first glimpse of the healing power of the animal-human bond over 40 years ago when he owned a riding stable in Kentucky. "There was an autistic boy whose mother brought him to the stable every week. The child could barely talk at all – but he knew all the horses by name."

Children in crisis seem to especially relate to Sundance and Corky, these two magnificent creatures who seem to display the courage to overcome their unfortunate beginnings – a fact Gress likes to point out to her younger clients. "These horses have triumphed over their troubles," explains Gress. "Fog Hollow is like a resort to Sundance and Corky. They're really enjoying life now."

The horses' ability to persevere and thrive also helps to illustrate the benefits of following medical advice, a necessity children can be hard-pressed to accept. Children who require medications as part of a treatment track can readily relate to the horses' need for medications. As Gress says, "The horses take their medicines to feel better, just like people need to."

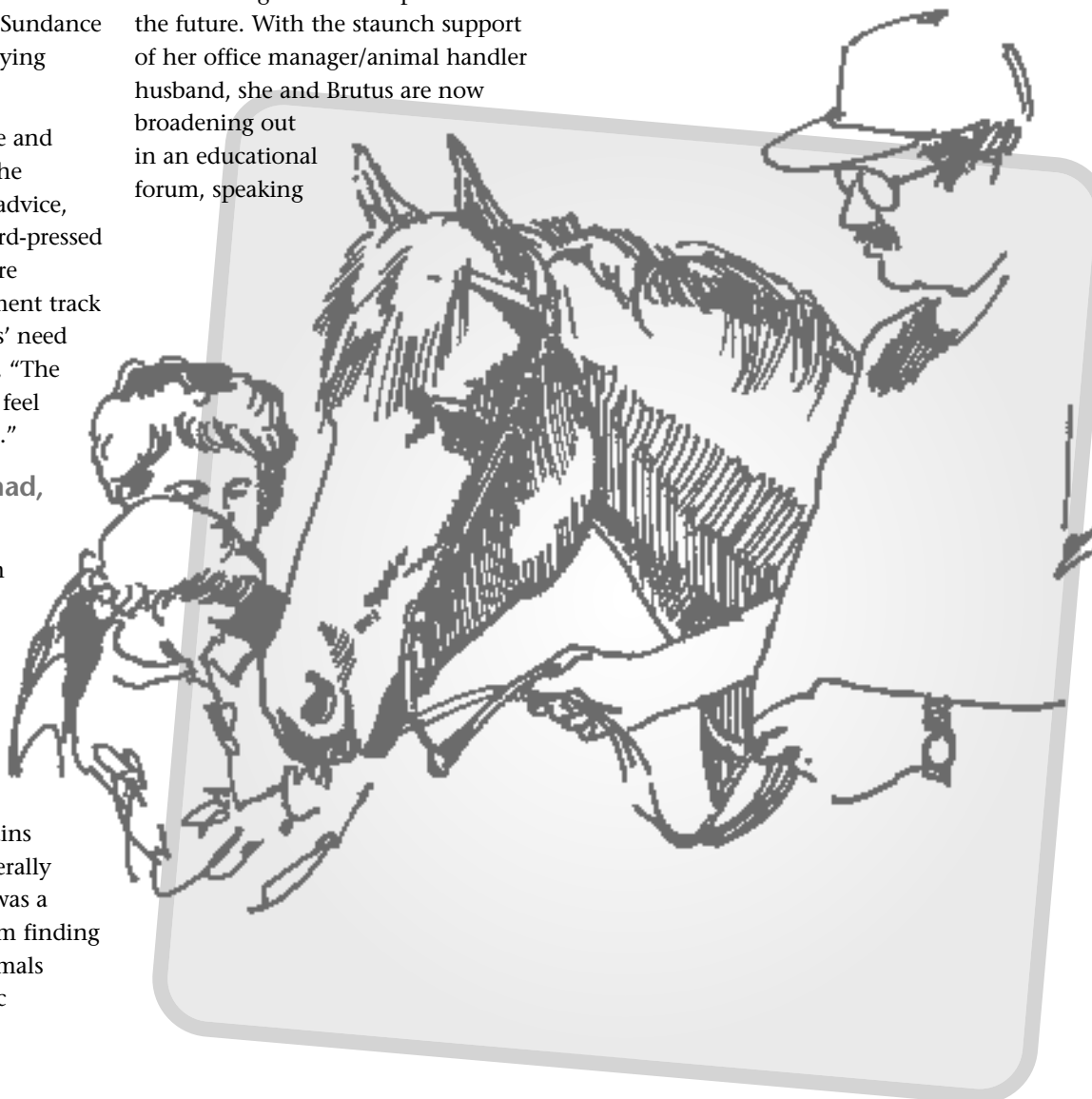
"When big people get mad, that's what happens"

By fostering the bond between humans and animals, and closely examining the similarities between the two, Gress and others are finding more and more just how relevant our treatment of companion animals is to our treatment of each other. Explains Gress, "In the past, it was generally thought that domestic abuse was a signal for animal abuse. But I'm finding that the reported abuse of animals often leads us to find domestic violence."

Gress tells the tale of a young boy in her neighborhood who stopped her to pet Brutus. "He told me that his dog had been thrown across the room, and had a sore leg," recalls Gress. When she asked how it happened, the boy stated, "Well, when big people get mad, that's what happens. BOOM!"

By investigating the animal abuse, Gress soon discovered that both the child and his mother were also being traumatized. "It's a very sad state of being," Gress continues. "However, we can now get help for the animal, the child and the family members. We are now equipped with the tools that can help break the cycle. More and more people today are getting the help, the consistent help, that they need."

Leading people to find that help is one of Gress' largest ventures planned for the future. With the staunch support of her office manager/animal handler husband, she and Brutus are now broadening out in an educational forum, speaking





Clockwise from left: Brutus with a feather in his cap; Ben, Gress and Brutus carting kids around a park; Muchka and Ziggafouse all dressed up with somewhere to go.

and seminars. Gress' enthusiasm for AAT seems to be catching on: she has noticed a marked increase in psychology students contacting her for references for related academic projects. Gress also acts as a consultant to hospitals and organizations interested in incorporating AAT into their treatment tracks.

Says Gress of her sometimes grueling schedule, "It's a lot of work, but I believe if you start with a positive frame of mind, you'll succeed." Yet, Gress remains careful not to let any member of her team get burned out – play time and "veggie" time are aggressively marked into everyone's calendar.

And as a special thanks to Brutus, who carries the heaviest work load on his broad shoulders, Gress enrolls him as a display dog in animal conferences. Here – while others demonstrate the how-tos of hands-on-healing therapeutic touch for animals – Brutus is treated to a head-to-toe body massage, so he can slip blissfully into a state of mental and physical relaxation.

Many clients also bring their own gifts of thanks to Brutus and friends: bones, treats or new accessories are just some of the ways clients have expressed their gratitude. And Gress offers special keepsakes, such as videotapes of sessions or self-affirmation cards with a picture of the animals, for clients to remember the unique bond they have shared. "One little girl wears a bracelet to remind her of 'when I was with Brutus,'" says Gress.

Gress also encourages clients with pets at home to "take back what they have learned" to utilize their own animals in a therapeutic way. Some clients have intentionally misinterpreted her advice a bit, jokingly attempting to "borrow" an animal from the Healing Arts office. Gress recalls one client who, in a most conspicuous manner, got up to leave with Muchka half-tucked under her coat.

However, Gress does not advocate that clients go out and get a pet. More often than not, she advises against it. "A pet is a commitment for life," explains Gress. "To properly care for a pet, one must have the needed resources, or the animal can become a source of stress."

When a client expresses a strong interest in owning a pet, Gress encourages him or her to start with a “virtual” pet, now readily available anywhere toys are sold. “Even these tiny electronic pets require a surprising amount of work. They teach so much about the responsibility of owning a pet.”

For Gress and Ben, the work involved in keeping their treasured brood is a labor of love; the rewards they have reaped and shared with others have far outweighed anything that could be considered a bother. Even the fact that people remember her animals and sometimes seem to all but forget her doesn't trouble Gress in the least.

“When I'm out walking, people always say, ‘Good morning, Brutus!’ And then they sort of look at me as if to say, ‘Who are you again?’ But I don't mind... he's a real show-stopper.”

For questions about Animal-Assisted Therapy, contact Kathryn Jean Gress at Healing Arts With Natural Therapy, 142 West Main Street, Macungie, PA 18062/(610) 966-3428.

Resources

Animal-Assisted Therapy

<http://www.aat.org>

A Therapy Dog Program

<http://www.doglogic.com/therapy.html>

Delta Society Pet Partners Programs

<http://petsforum.com/deltasociety/>

Dog-Play Therapy Dog Web Site

<http://www.dog-aplay.com/index.shtml#TOC>

Pawprints

<http://www.netreach.net/~dhoffman/pawprints/special.html>

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“Cognitive Therapy With Depressed and Suicidal Adolescents”:

A National Hospital seminar presented by Cory F. Newman, Ph.D.

Part I of a two-part series

By Jennifer Whitlock, MA

Cory F. Newman, Ph.D., says he doesn't stop at correcting his patients' distorted cognitions. He also wants to correct the irrational beliefs many counselors hold about cognitive therapy.

“I want to shatter the myth that cognitive therapy is not personal, and that it's too logical at the expense of emotions,” Dr. Newman announced at a recent KidsPeace National Hospital for Kids in Crisis Grand Rounds/Continuing Medical Education Seminar. “Cognitive therapy is not just about changing people's distorted thinking. It's also about opening up people's minds to new ideas about who we are and what makes life worth living – including relationships, emotions, exploration of new possibilities and growth potential. I'm a cognitive therapist, but I integrate a humanistic streak with my therapy.”

Dr. Newman, who is the clinical director at the Center for Cognitive Therapy at the University of Pennsylvania and co-author of the book, “Choosing to Live” (New Harbinger Publications), started his lecture with some sobering statistics. “In 1995, there were well over 5,000 completed suicides in the United States for the 15 to 24 age group. The rate of completed suicides among adolescents has gone up 300 percent in the last 30 years.”

On the positive side, Dr. Newman stated that he has successfully treated teenage depression and suicidality using cognitive therapy. He described for his audience of nearly 200 youth professionals some of the strategies that have worked with his patients.

General principles of cognitive therapy with adolescents

Teenagers aren't just miniature adults. They're a whole different breed that thinks and acts differently from grownups. They're known to rebel against adults, including therapists. And to make it more complicated, most teens don't want to be in counseling in the first place. They're more likely to be dragged into therapy kicking and screaming – or at least sneering – because it's their parents who have a problem with their behavior.

Dr. Newman listed several ways a therapist can customize cognitive therapy to fit a teenager's unique needs.

Be creative to stimulate interest in the session. Because teens can be so prone to being bored, and they probably don't want to be in therapy anyway, therapists have to entertain patients to some degree. “It doesn't jibe with our training, and it sounds unseemly, but you've got to entertain them or you'll lose them,” Dr. Newman emphasized. “One of the best ways to engage them is to disguise your therapy as clever conversation.”

Being stimulating means forgetting about the psycho-jargon. “Don't flaunt your authority or your knowledge,” Dr. Newman warned. “Remember, you've got the stronger ego. You don't have to advertise, ‘Here's what I know.’”

Speak in a more casual language.

But, Dr. Newman added, don't try to be cool. "I've been guilty of trying to be cool too often, and I've been laughed at."

Learn about their interests. "Many teens are much more willing to let you teach them something if you let them teach you something first," Dr. Newman said. "I've learned about music, celebrities and computer games. I thought I was pretty up-to-date on those things, but I was wrong. I might ask, 'For you, what's the difference between Alanis Morissette and Fiona Apple?' I'll get a 10-minute dissertation on the subject. That's great. I've learned. And I've also earned some points for letting them be the expert on something."

Better yet, do some extra credit work. "I had a 13-year-old patient who had a shrine to Kurt Cobain in her room. She sometimes talked about how 'maybe Kurt had the right idea,'" Dr. Newman related. "I bought two Nirvana albums and learned the lyrics. I was able to draw upon them in our sessions, saying things like, 'Gotta find a way to find a way.' When, after a particularly difficult session, she sarcastically quoted from Cobain, 'I'm forever in debt to your priceless advice,' I was able to respond, 'All Apologies,' which is the title of the Cobain song."

Use catchy images and metaphors. "I had a 15-year-old male patient who was 'big time' on basketball," Dr. Newman recalled. "He dropped hints that he would complain to his parents about me, so they would pull him out of therapy and I'd lose a paying patient. Of course, I get a salary from the university. If I lose a patient, I don't lose money. I get a free hour. But I didn't tell him that."

Instead, Dr. Newman said, he created a basketball metaphor to keep the patient interested and show him he could benefit from therapy. "I said, 'I think, to some degree, this is like a basketball

team. I'm the coach, you're the star player, and your parents are the team owners.' I could see his antenna go up then. I added, 'What I mean is, the owners call the shots. If there's a conflict between the star player and the coach, who do you think goes first? The coach. You and I both know that. So I could be fired any day now. That's a chance I'm going to have to take. Because my role as a coach is to get the most out of my team as possible. And I think I'm not getting the most out of this team right now.' That stuck in his brain more than 20 other lessons I thought I was teaching him."

Dr. Newman steals metaphors from TV shows, video games, movies, comic books – anything that might stick in an adolescent's mind. He said he once told an aggressive 17-year-old, "You're a lot like Darth Vader. You're powerful. You wind up influencing a lot of people... But you have to make a choice. Will you stay with the Luke Skywalkers of the world, or will you go the Dark Side of the where your powers w for evil?"

Be nice, but set limits. The best teachers aren't the ones who let kids get away with bad behavior. "The good teachers – who kids actually listen to and learn from – are the ones who don't shame students, who listen, who, even if they disagree, will show respect for the adolescent's point of view," Dr. Newman said. "They also set standards. They don't say, 'Do whatever you want. Who cares?' They let it be known that they have faith in their students. Faith enough to demand more – not because they're mean, but because they know the students can do better. Their actions say, 'I think you can do better than that. In fact, maybe I've got more faith in you than you've got in yourself.'"

Dr. Newman said that the best time to set ground rules about phone contacts, attendance and acceptable behavior in the session is on the first visit. "The first thing one teenager did when he got into my office was put his feet on my desk," Dr. Newman remembered. "I said, 'Was this your office in a past life?'"

Be even-tempered and nonjudgmental. That doesn't mean you have to talk in a monotone. "You can be dramatic and still be even-tempered," Dr. Newman said. "What I mean is, you don't get too angry and judgmental, and you don't get real passive and permissive



either. You tell the patient you're concerned about the behavior, but you don't say, 'Oh my God, how bad! How could you?'"

Be a good directive listener. A good directive listener doesn't passively say, "Uh huh, uh huh, uh huh," while the patient is expressing self-destructive thoughts. Nor does the good directive listener tell the patient what to do.

"Cognitive therapists are directive in the sense of, 'I'm going to summarize what you've been saying. I'll be your mirror. I'm going to tell you what you

even if YOU forgot at it.' That's a good ctive listener," Newman said.

Utilize questioning to get young patients to participate. Instead of showing patients list of distorted think-

ing patterns, gently probe their thoughts. "Ask them, 'When your friend made that comment to you, and you absolutely went to pieces, what did you make of that?'" said Dr. Newman. "That kind of questioning stimulates their interest and subtly socializes them to their thought process as mediator of their experience."

Boost efficacy by teaching methods of self-instruction. Lecturing isn't enough. "First of all, teens are resistant. They're trying to find their own way, and they're rebelling against authority as part of the normal process of development," Dr. Newman said. "But they also need to have ways of talking to themselves so they're not just having knee-jerk reactions.

"In your discourse with your teen patients, inquire, 'When you could just go off on this teacher and maybe get expelled, OR you could size up the situation carefully and figure out the smart way to get your way, what are you going to have to remind yourself so you don't wig out?' I repeat that

question and introduce similar questions. 'What are you going to have to remind yourself at that moment?' Or, 'What will you have to say to yourself to keep cool?' Or, 'What will you have to think about doing that's going to work for you instead of blowing up the situation sky high?' It's almost like a subliminal persuasion technique.

"Even if they don't like the principle that you're advocating – which is, 'Keep cool' – they do like the principle of 'What do I have to do to get what I want?'"

Elicit feedback and summary statements. Feedback is another way for the patient to feel in control. Dr. Newman said, "Ask, 'What do you think about what I'm saying? Does this have any relevance to your life whatsoever? Am I just going on and on like some stupid adult who has no clue?' If the answer is, 'Yeah, you are,' then ask, 'How can you put me straight?' Be willing to make yourself a foil. Not that you'd be self-deprecating. More, a part of a comedic team. You can be the straight man. Let them bash you a little bit. It's all a part of learning. Find out what they think."

Take the teenager's feelings seriously. Never make the mistake of minimizing a patient's emotions. And don't let them minimize their feelings, either. "One patient told me, 'I'm just a kid; you can't take me seriously,'" Dr. Newman said. "I told her, 'Don't insult yourself. What you're telling me is that your 14-year-old brain can't be taken seriously. That is so wrong. Your attitude now will shape your whole life. You can't just turn off a bad attitude when you leave home to go out on your own.'"

Be respectful of their privacy. "If you have a good rapport with your patients, they will eventually tell you everything. Sometimes, it's just about timing," Dr. Newman said. "You might ask, 'What happened with your boyfriend? You look sad.' If your patient says,



'I don't want to talk about it,' don't push. Ask, 'Can I reserve the right to ask about it again at some later point without your being insulted?' Then, respect her privacy. Keep the sensitive topic in the back of your mind to assess in the future."

Keep in mind that boredom is a red-flag for depression and low self-esteem.

"Boredom' is a vague term we hear a lot from teenagers," Dr. Newman said. "Often, it's a euphemism for 'I'm alienated,' 'I feel empty,' 'I have no direction,' 'I feel helpless,' 'I'm unhappy' and 'I'm angry.' It's all those things in one neat, little, safe word. And being bored is power because you can trash anything. As a therapist, you can stand on your head or weave poetic phrases in and out of the session – then, the patient yawns. Don't take it personally. Just realize it's a red flag that there's something else going on. I try to provoke teenage patients by saying, 'Anybody with an imagination can avoid being bored.'"

Watch for Part II of "Cognitive Therapy With Depressed and Suicidal Adolescents" in the next issue of "Healing Magazine."

To learn more about KidsPeace National Hospital for Kids in Crisis Grand Rounds/Continuing Medical Education Seminars, please call (610) 799-8851. This series is jointly sponsored by MCP/Hahnemann School of Medicine and National Hospital for Kids in Crisis. Seminars are approved for CME, CE (psychologist and Pennsylvania social worker) and NBCC credits.

Warning signs for adolescent suicidality

Dr. Newman advises therapists to watch for these "red alert" behaviors:

Sudden withdrawal from friends, family and regular activities

"Some depressed teenagers have a long-term history of being withdrawn. Even more acutely, I'm talking about kids who have been social and who have done activities, then suddenly show withdrawal. Many of the signs of suicidality overlap with the signs of drug use, and this is one of them. Let's say you have a kid who was into soccer and into the book club and into the Internet, and now he's sleeping all day, doesn't want to play soccer anymore, won't take phone calls from friends. That's not just laziness. That's not just obstinacy. It could be depression. Or it could be worse than that."

Violent or highly rebellious behavior

"Violent acting-out can be a cover for feeling so bad that you want to die. Sometimes, the attitude is, 'I don't care about myself anyway, so if I get put in jail or killed in a gang fight or killed by an overdose, who cares?' They act real tough to overcome a sense of low self-esteem."

Drug or alcohol abuse

"Chronically and acutely, drug and alcohol abuse increase the risk of depression and suicidality."

Unusual neglect of personal appearance

"I'm not talking about a stereotyped 'in' way of looking, such as the Grunge look. I'm talking about a person who suddenly seems to not care about what he or she looks like. You know how all-consumed teenagers are about their appearance."

Decline in quality of schoolwork, truancy

"When a kid starts a new school, he or she might have a temporary drop in grades. That's normal. But a kid who never failed a test and who suddenly has two failures might have a problem. It could be the onset of drug abuse. Or it could be suicidality and depression."

Running away

"Running away, as well as suicidal gesturing, may be an attempt to escape an intolerable situation. They may also be a sign that something's going wrong within the family."

Excessive fatigue and somatic malaise

"I'm not talking about a teen who was on the Internet until three in the morning. I mean chronic fatigue that is a byproduct of depression."

Poor response to praise or rewards

"Normal teens like praise and rewards. If they're indifferent to praise and rewards, something's wrong. Now, some teens pretend to be indifferent to punishment. That's normative. But even teens with that mentality are receptive to the good stuff coming their way."

Verbal hints, overt threats about suicide

"This category may include nihilistic comments: 'We're all going to die anyway'; 'What's the point in going on?'; 'It's all pointless'; 'The world's so cruel'; 'Life is dumb'; 'It's better in the after-world'; 'I want to be with Grandma.'"

Giving away prized possessions

"This is a suicide marker for anybody, but especially teenagers because teenagers normatively really guard their stuff. Don't touch their stuff. Don't move their stuff. Don't criticize their stuff. If they're giving away their stuff, think 'depression.'"



Effecting change in children and adolescents through dance/movement therapy

By Beth Ann Finisdore, MA, DTR
National Hospital for Kids in Crisis



Six-year-old George* walked into the Movement Therapy Room with a sullen frown on his face and his arms crossed. He sat down on the floor among the circle of children who had assembled for the exercises, but he refused to respond to the therapist's greeting.

The other kids continued to prepare for the warm-up by taking off their shoes and moving into the first position: feet together, as if they were clapping. Next, they pretended that they were boats sailing in the ocean, while each told of the places where he or she would sail. Then, the children turned their bodies into cradles to "rock a baby" in a tree.

George kept his arms crossed. Yet, almost in spite of himself, his body began to rock slowly back and forth. As the group went on to climbing an imaginary rope, George sat taller and straighter. He looked up at the children standing and reaching around him. One, then both, of his arms came uncrossed. He seemed to be getting ready to join the others in their fantasy world.

On a cue from the therapist, the group began tugging at the "rope" to keep from falling forwards, backwards,

sideways. George was now holding on, too, his torso bending in the many different directions.

The warm-up drew to a close with kids scattering every which way to find their own "place" before the music started. Out came the colorful scarves – and a big smile from George. The small child quickly raised his hand to ask to dance to his favorite song. Before long, he was twirling the scarf and weaving around his peers, trying out different movements in the three levels – low, medium and high – of space.

When the dance ended, George helped fold the scarves. By the time the session was over, he had even talked with the other kids about his experience in the dance/movement group.

Dance and movement change emotional states

Moving can change the way you feel – often, for the better. Almost everyone



has had the experience of finishing a long day at work, only to remember that a workout at the gym or an aerobics class still loomed ahead. You think about skipping it, but you don't want to end up feeling guilty; so, you push yourself to go.

It's not till afterwards that you are glad that you went. Your energy is back. And you feel better and healthier.

Dance/movement therapists report similar changes in the emotional states of their patients during or after sessions. Studies have shown how a position of the body may create a certain mood or feeling. They have also demonstrated a connection between movement and the feelings reported by the subjects being observed.

The mind and body are interrelated. There is scientific proof that impulses from the brain pass through the limbic – or emotional – system to affect how the body moves. Simultaneously, the way the body moves sends impulses back to the brain. Such impulses can cause changes in emotions.

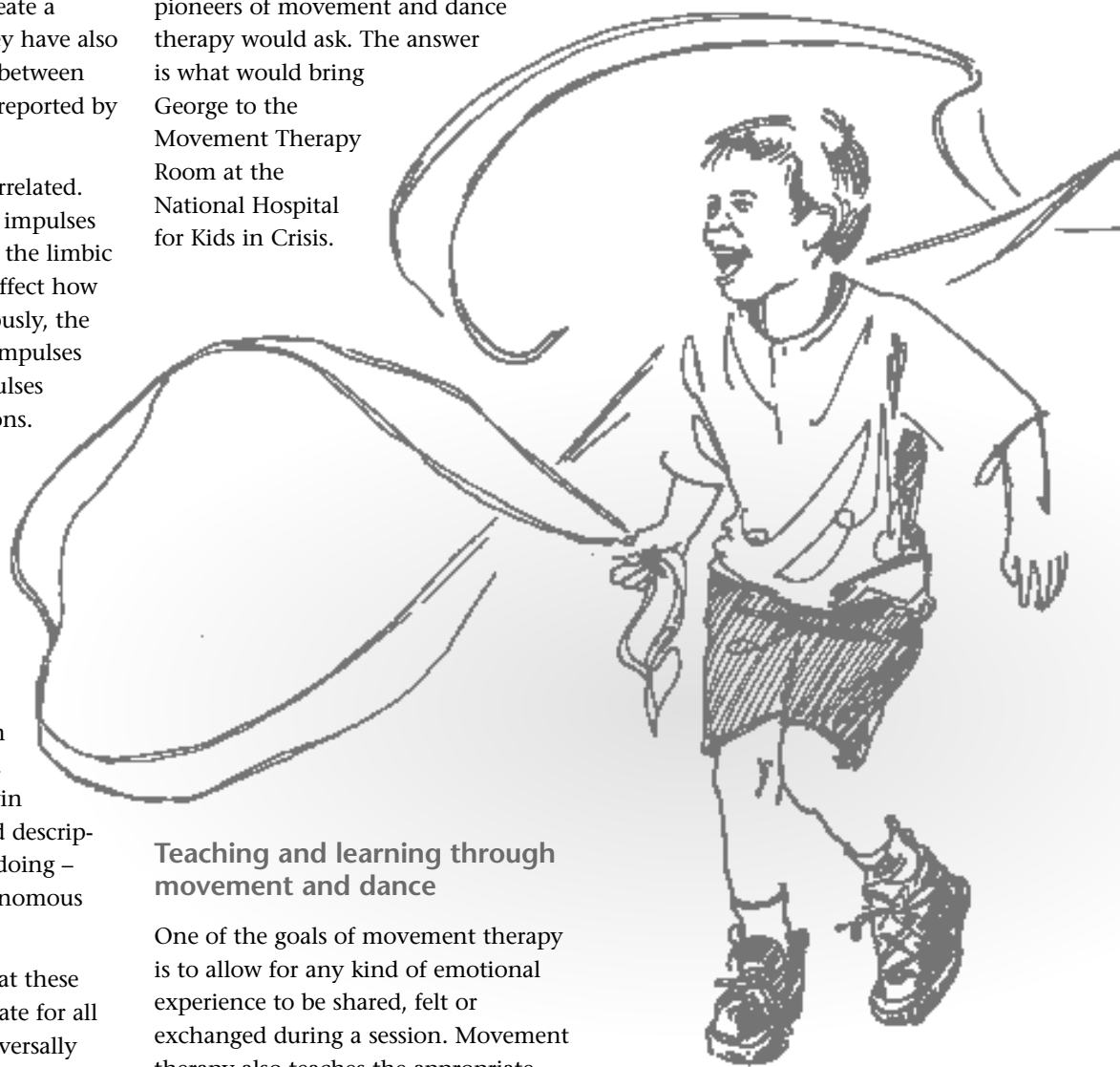
A number of observational studies have documented the physiological processes that occur during certain emotional states. Charles Darwin was the first to identify the universal physical expression of various emotions in "The Expression of the Emotions in Man and Animals." In his work, Darwin gave detailed definitions and descriptions of what the body was doing – on voluntary as well as autonomous levels – during these states.

Further, Darwin reasoned that these emotions were probably innate for all humans since they were universally recognized. These feeling states, he said, were not learned behavior. There might be cultural differences in how people greet one another in the street, but there is no difference in how they express joy.

Darwin's example was one of a blind and deaf girl who had no external way of learning to express joy in the physiological form. However, she expressed the feeling in the same way that all humans do.

The implication was that feelings and their physiological expression are linked. And, when understood, such physiological expression is another form of human communication – the unspoken language of the body.

But what if expression could also shape feelings? That was the question that the pioneers of movement and dance therapy would ask. The answer is what would bring George to the Movement Therapy Room at the National Hospital for Kids in Crisis.



Teaching and learning through movement and dance

One of the goals of movement therapy is to allow for any kind of emotional experience to be shared, felt or exchanged during a session. Movement therapy also teaches the appropriate channels and means for expressing emotions. Dance therapy – with or without the accompaniment of music – is a deliberate attempt to call up an emotional state through movement.

I personally recall being asked by a former instructor to do a dance improvisation as if I were happy, then sad, then angry. At the time, I could remember having experienced these emotions in my everyday life; I knew what it was like to feel and move as if I were currently experiencing them. Therefore, I was able to follow through on the instructor's request.

But what about the person who has never felt a certain emotion before and has no body memory or cognitive memory of that type of emotion? I cite as an example the chronic schizophrenic patient whose emotions have been repressed and denied, thus causing the body to distort. These schizophrenic patients are often experiencing only one emotion in a constant state.

Since chronic schizophrenics are generally nonverbal, a dance therapist could work with the patient and introduce new movements – or simply change the way the patient is holding his or her body. Either will cause changes in the information that is being sent to the brain, thereby changing the feeling state.

Even though Darwin had been able to describe, on a universal level, how certain movements are associated with certain emotions, he only named and described a few emotions. He recognized that there are other complex emotions that are much more difficult to read physiologically, particularly in healthy humans. If we were to hold an

improvisational class with these healthy humans and ask them to move as if they were suspicious, we would see that not everyone has the same interpretation of suspicion on a physiological level. Rather, each person has an individual style and form of movement. Thus, each person would have his or her own interpretation of the feeling state of "suspicion."

We have learned that each person has a singular interpretation of an emotion, and may express that emotion on a bodily level in a unique way. For this reason, we cannot label a certain kind of movement as a certain emotional state. We can agree, however, that when movement does occur, a change in emotion also occurs.

Movement gives kids a "voice"

The American Dance Therapy Association defines dance/movement therapy as "the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual." As defined, movement therapy effects changes in feelings, cognition, physical functioning and behavior.

When children socialize and play, they naturally use nonverbal games and activities. The playful nature of movement activities establishes cohesion, cooperation and communication within the group.

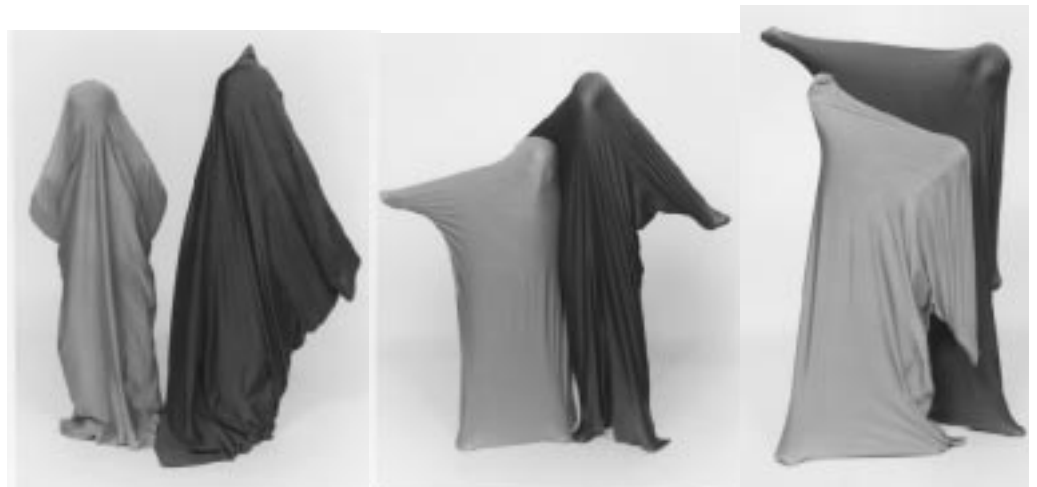
Movement is our most basic means of communication. It is on a non-verbal

Moving bodies, making art, having fun

The children you see pictured here are wearing BodySox, which is used in our Movement Therapy classes. BodySox serves as an elastic "shield," protecting kids from vulnerability as they express their deepest emotions through the art of dance and movement. The imaginations of the kids who watch are stretched along with the material, as it changes form and "becomes" new and intriguing shapes.

BodySox™ was created by Kimberly Dye, MS, DTR, and manufactured by Sportime® of Atlanta, GA.

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level that we first learn about the world and how to interact with it. As people grow and develop, they learn to communicate verbally. But physical and psychological difficulties may prevent some clients from expressing themselves verbally. Structured movement activities allow for these clients to find a “voice” through movement.

As clients learn to use their bodies more effectively, we see improvement in coordination, self-esteem and body image. Structured movement activities allow each member of the group to take turns being the center of attention and demonstrating strengths.

Movement games are fun, creative and playful. They allow a client to give and receive feedback on verbal and nonverbal behavior. The activities prompt clients to recognize alternative and more adaptive ways to fulfill their needs.

Therapy in action

Here are a few basic therapeutic movement and dance activities that you can try in almost any setting.

MIRRORING ACTIVITIES

Mirroring activities help to increase communication and encourage empathy. As empathy builds, clients become more comfortable in expressing their feelings.

NAME GAME

Have the group stand in a circle. Tell them that, one at a time, each person will do a movement that represents his or her name while saying that name. Everyone will then repeat the movement and say the name of the person. After the first person goes, the person to the left creates a movement to correspond to his/her name, and the group imitates the second person’s movement. Then, the group “moves” the first person’s name and the second person’s name in order. Each individual adds on until there is a sequence of name dances. Once the last person in the circle has gone, there will be many names and movements to remember. Encourage the group to do the sequence without saying the names to create a group dance. Try to make each movement flow into the next. The dance can be performed to music or in silence.

Variations/adaptations

Do the sequence of movements faster or slower.

Ask the group members to pick a movement that shows how they are feeling.

Pick a name movement and make it larger and larger and larger, then smaller and smaller and smaller until it practically disappears.

Ask if anyone wants to perform a solo doing everyone’s names.

Reverse the sequence, or mix up the order.

If clients have a limited range of movement or a small space to move in, ask them to choose a gesture (nothing profane!) instead of a full body movement.

Freddie’s turn

Freddie, an adolescent boy who was joining one of our groups for the first time, was reluctant to play the Name Game. He stated that he did not need to be in the hospital. Still, he remained cooperative and followed instructions. As it got closer to his turn, I could see that Freddie was doing the movements more fully and with more attention to details. When his turn came, he was ready. He brought his thumb up to his nose and wiggled his fingers. This action brought laughs from the other group members. Everyone did the movement together, and Freddie felt like he was a part of the group. He then shared why he was in the hospital, and how confused he felt about what was happening in school.

MIRRORING

Ask the clients to split into pairs. One client of each pair leads the movements for his or her partner, using slow and easy-to-follow steps. The other partner provides the mirror image, following as best as possible. After several minutes, ask the clients to switch leadership. Then, invite the pair to



switch leadership on their own, without talking. This activity will produce giggles, so clients will have to be reminded not to make noise. Encourage movers to use different levels of space (high, medium or low) and more complicated movements, but reiterate that they must keep the movement slow so it can be easily followed. After several more minutes, ask each pair to combine with another pair. Allow the mirroring in the foursome to continue for a few minutes, then direct the

groups of four to merge
into groups of
eight



and so on until the entire group is moving in a similar manner. At this point, you may designate a leader, but follow by giving each person equal time to lead. The final leader, who could be staff, should be encouraged to find a natural way to end the movements.

Variations/adaptations

Instead of having partners join with other partners, ask partners to find new partners.

Try this activity with soft, relaxing music.

Do the exercise with groups of three if you have an uneven number of clients present.

Liz and Julie's turn

After many attempts to get several adolescent pairs to focus and create movements that were not so silly that we would have to start over because of the ensuing laughter, the clients began Mirroring. Soon, I noticed one pair staying focused and clear, and moving consistently and smoothly without stopping. I quickly asked the rest of the group to watch and see how Liz and Julie were mirroring each other. Donald watched for a while, then asked, "Which one of you is the leader?" Liz and Julie froze and stared at each other for a moment. Julie then said, "I don't know. I forgot." Liz shrugged her shoulders. I pointed out that Liz and Julie were able to empathize with each other because they were listening and responding to each other's movements and rhythms. "Neat!" was exclaimed by John, Don's partner. The two males went off to try again. The rest of the group was able to put more attention and focus into the activity. Later, everyone was able to talk about what they had learned about their partners' movements. The experience then led to a discussion about trying to understand

other people, and trying to communicate with them more effectively.

IMPULSIVITY ACTIVITIES

These activities allow clients to experience the sensation of waiting, and demonstrate for them their ability to control their impulses. As the clients gain mastery over their actions, impulsivity and aggression decrease.

MOVE AND FREEZE

Tell the clients that they can move or dance in any way they want to when the music begins. They must freeze when the music stops. Encourage them to freeze in different shapes or levels.

Variations/adaptations

Ask clients to freeze in different characters, or call out an emotion that you would like to see them express when they are frozen.

Tell half the group to freeze when the music starts, and the other half to freeze when it stops. This creates two groups, allowing the dancers to move around the frozen shapes.

Use scarves, bubbles or balloons to enhance movement.

Play different kinds of music, and ask the clients to move the way the music makes them feel.

ISLANDS

Place circular hoops or "islands" a few feet apart around the room. Tell the clients that these are islands and that the rest of the floor is the ocean. When the music begins, everyone may move in the ocean, swimming or dancing on the water. When the music stops, each person must touch an island. Islands may be shared, but clients may not touch each other. After each musical pause, an island is taken away until only one remains. Again, the object is to find a way to touch the island without touching another client. If conflicts arise over an island, remind the clients that they must share and that they can touch an island with a peripheral body

part such as a toe or finger. This activity and those that follow help clients to become more aware of the space around them, their own personal space and boundaries.

The preadolescents' turn

The preadolescent group had been having a difficult time getting along all week. They were picking on and blaming one another for how they were feeling. And they were lecturing on why they were not doing well in groups. There was name calling and fighting that led to many time-outs and much frustration. After briefly explaining the game of Islands, I put on a variety of upbeat and high energy songs: "The Peppermint Twist," "Space Jam" and "Rockin' Robin." Some of the kids just walked around at first, avoiding their peers and waiting for the music to stop so they could take an island. Others began showing off their moves as they danced in the ocean. When the music stopped, I pointed out how neat some of the movements were, and named the people who performed them. "Anthony, those were great spins you were doing, AND you managed to avoid getting too dizzy and bumping into people!" I exclaimed. "Sylvia, you got your feet up so high with those kicks!" Soon everyone was trying out moves to get some positive attention. As the islands became fewer, I checked to make sure that no part of anyone's body was touching another's. Once everyone was sharing the last island, I complimented them on finding a way to work together to fit all eight of them onto the hoop-sized island. We, then, sat down and had a discussion. With one person talking at a time, the clients were able to listen to each other's stories about the difficulties of getting along with family and the people at school.

SCULPTURES

Tell the group that they will be making a sculpture. Ask a volunteer to walk into the center space and make a shape

with the body that could be held for a while. Next, ask another person to walk into the space and create a shape with at least one element the same and at least one element different than the first person's. For example, if the first volunteer stands with arms and legs in an "X" shape, the second person could lay on the floor (different level) with arms and legs in an "X." Or, the second person could position the legs in the same manner, but the arms differently. Continue letting each member of the group add on to the sculpture. If necessary, remind them of the rules. And let them know that their "sculpture" is three-dimensional, so they may face in any direction. When the sculpture is complete, encourage clients to be aware of the shapes they made and the roles they played in the whole sculpture. Give them four counts or claps to change to a new shape. Comment on how the sculpture has changed. After several rounds of changing, a different person starts the sculpture.

Variations/adaptations

Choose a theme for the group sculpture. (I sometimes use "Little Red Riding Hood," a football game or animals in a zoo.) Or allow the clients to choose a theme.

Have each person physically connect with another person.

Split the group into two. Allow each subgroup to create its own sculpture, then show it to the other subgroup.

Divide the groups into smaller groups of three or four members. Have each subgroup secretly choose a fairy tale, then decide on three sculptures or "scenes" that will help convey the story. Everyone must participate in the sculptures. After giving 10 to 15 minutes to plan the sculptures, instruct the first subgroup to "perform" its story for the other subgroups to guess. No guesses should be called out until the subgroup has completed all three of its sculptures. Repeat for the other subgroups.

PERSONAL SPACE

Explain to the clients that their “personal space” is all the space that they are in and that they can reach while being in a stationary position at any given time. Ask each client to sit alone in a “space,” far enough apart to keep from touching anyone else. Put on soft, relaxing music, and direct the clients (You can do it, too!) to slowly reach out with their hands and arms, and explore all the space around them... in front, behind, next to, above and underneath. Next, have them do the same with their legs. Tell them to stretch these parts of the body in all possible positions – one at a time, alternating, both together, over the head, to the side, crossing over. Ask them to find new ways to stretch. Then, ask them to get into a standing position slowly.

While standing, they should keep their feet stationary, but stretch their arms and bodies in all directions. Have them explore all the space around them.

Variations/ adaptations

For clients who need more structure,

outline with a hoop or a mark the place on the floor where they cannot move from.

BOX DANCE

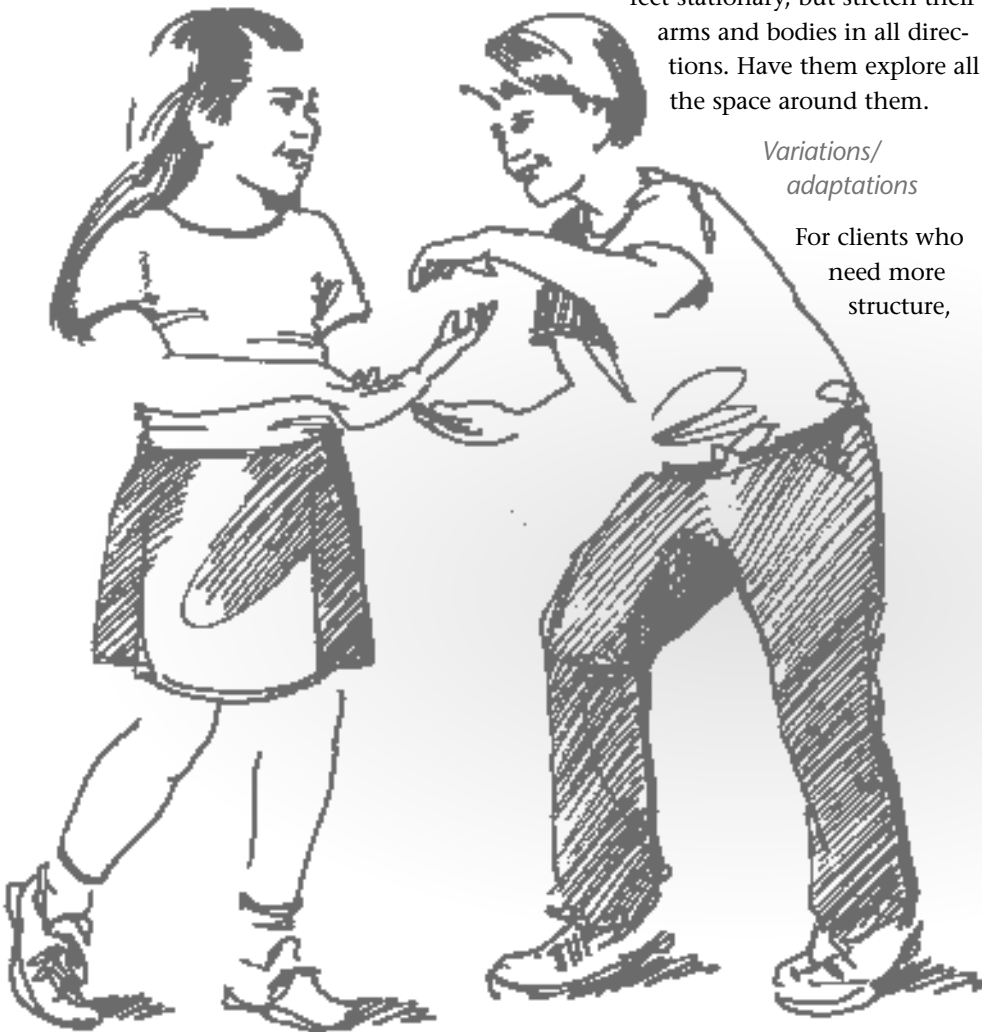
Ask each client to sit alone in a “space,” far enough apart to keep from touching anyone else. The space represents a “box” that the client is in. Put on soft music, and have the clients explore the inside of their “box.” Have them take some time to feel the ceiling. The four walls. The floor. How large is the box? How small? What are the many creative ways in which they can move in the box? How does their body fit in the box? How do they feel inside the box? Can they find a way to get out of the box? Or are they comfortable and want to stay in their box?

Josh’s turn

Josh was having difficulty with his personal space awareness and boundaries. The 10-year-old would often “fall” into people while sitting in a circle or bump into them while dancing around the room. Josh even had trouble walking in a straight line without bumping into the person in front of or behind him.

With some support from the staff, Josh was able to imagine the “box” he was in and explore different ways of moving in that box. Josh was asked to make walls for the box, then remember that he could not make any movements that were larger than the walls would allow him to make. It was a challenge for him, but he received a lot of praise for the good job he did as he got better and better at staying in his box.

When the group did warm-ups the next day, Josh began “falling” against his peers once more. I asked to remember the box and to put himself in it while he did the warm-ups. There were no more problems with Josh maintaining his boundaries for the rest of the time in group.



CLOSURE ACTIVITY

A closure activity is a great way to end a group and calm everyone down. It also increases creative thinking.

MAGIC METAMORPHIC BALL

Have all the clients sit in a circle. Start by miming an imaginary ball. Then, announce that the ball can be molded and shaped into anything the clients wish. (You can shape something – a flower, feather, shoe, marble or other object – as an example.) Once someone has guessed what the object the first person shapes is supposed to be, the object is shaped back into a ball and passed to the next person. Repeat until everyone gets a chance to shape the ball. The second time around, ask each client to create a gift for the person on his or her right. After the gift is given, ask what it is and why it was chosen.

Variations/adaptations

For lower functioning groups, pass a real ball around several times before you ask the clients to imagine a ball.

Try the gift-giving exercise with smaller subgroups or with partners.

What about George?

Today is George's last day in the group. He takes his time creating a gift for the person on his right during the Magic Metamorphic Ball closure activity. His movements are flowing and slow, but he wears a smile on his face as he works. When he is finished, the person on his right asks him what he has created for her.

"Three new scarves to put in the scarf bag!" George proudly declares.

Of course.

Call or e-mail Beth Ann Finisdore with your questions at (610) 799-8810/baf@fast.net. Or write her at National Hospital for Kids in Crisis, Expressive Therapies Department, 5300 KidsPeace Drive, Orefield, PA 18069.

* Names are changed.

Beth Ann Finisdore, MA, DTR, has been a dance/movement therapist at the KidsPeace National Hospital for Kids in Crisis since 1996. She was on staff at the Kardon Institute of the Arts for People with Disabilities, where she taught dance to children and adults with physical, emotional and mental disabilities. Her responsibilities included an outreach program teaching dance at the Pennsylvania School for the Deaf. Finisdore taught modern dance and ballet at the Germantown branch of the Settlement Music School. She has been teaching ballet, jazz and modern dance techniques for children and adults for over 10 years. As an actress, she traveled and performed with the Children's Repertory Company in productions about contemporary social issues. When she was not on the road, she worked as a recreational counselor for the Devereaux Foundation. She has choreographed and performed dance pieces in New York and Philadelphia, and done choreography for such children's theatre musicals as "Peter Pan," "Charlie and the Chocolate Factory" and "The Wizard of Oz." Finisdore received her master's degree in dance/movement therapy from Hahnemann University in Philadelphia, and her BA in dance and drama from Bard College, New York.

Resources

American Dance Therapy Association

2000 Century Plaza, Suite 108
10632 Little Patuxent Parkway
Columbia, MD 21044-3263
www.adta.org

"A Moving Experience" and "More Moving Experiences"

Teresa Benzwie, Ed.D.
Zephyr Press
P.O. Box 66006
Tucson, AZ 85728-6006

"Body Movement: Coping With the Environment"

Irmgard Bartenieff
Gordon and Breach Science Publishers
820 Town Center Drive
Langhorne, PA 19047

"Dance and Grow: Developmental Dance Activities for Three-Through Eight-Year-Olds"

Betty Rowan
Princeton Book Company Publishers
P.O. Box 57
Pennington, NJ 08534

"Dance Movement Therapy: A Healing Art"

Fran J. Levy, Ed.D., MSW, ADTR
The American Alliance for Health, Physical Education, Recreation and Dance
1900 Association Drive
Reston, VA 22091

"Dance-Movement Therapy, Mirror of Ourselves: The Psychoanalytic Approach"

Elaine V. Siegel, Ph.D., ADTR
Human Sciences Press, Inc.
72 Fifth Avenue
New York, NY 10011



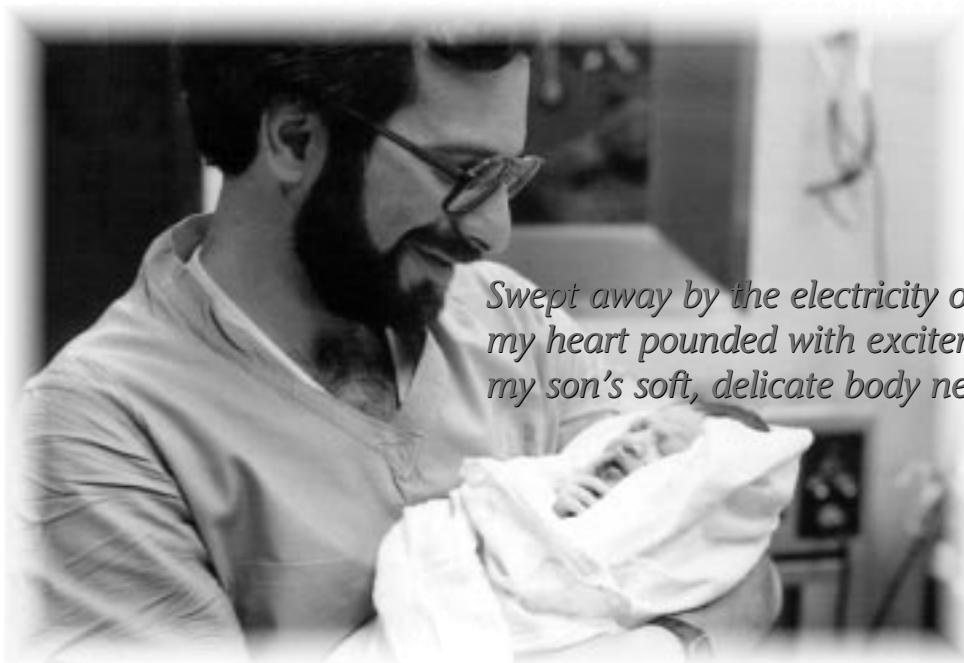
Especially for parents

An insider's view of the invisible challenges: understanding parents of children with mental, emotional and behavioral disorders

By Robert Naseef, Ph.D.

Are you the parent of a special needs child? Do you know someone who is? Then you may be interested in this moving account of one father and psychologist who found himself challenged by his child's condition – and his own expectations. From his personal experience, Dr. Naseef also offers advice on how clinicians can better serve their patients and their patients' families.

Bob Naseef holds his son for the first time in the delivery room.



Swept away by the electricity of the moment, my heart pounded with excitement as I held my son's soft, delicate body next to my heart.

Tariq was all I had dreamed he would be in those first instants of life as our eyes met and locked onto each other for the first time. Visions of playing baseball and building model airplanes together, and having a warm, close relationship danced in my mind's eye.

Tariq reached the usual milestones during his first 18 months of life. He rolled over; raised his head; began creeping, crawling, cruising and triumphantly walking. And proudly communicating with words.

Then he got an ear infection, and the train went off the track.

Grieving for what was, and what would never be

That exciting time when every day seemed to bring a new development was gone. I lived my life in a fog that came on as the great American poet, Carl Sandburg, wrote, "with little cat feet." My son stopped talking, stopped playing normally. He began flapping his arms in a strange, repetitive manner.

His life and mine were never the same.

After years of early intervention, my boy was diagnosed with autism and mental retardation. He never spoke again, and never learned to read or write. Now 18, Tariq is still extremely active. And he doesn't understand the meaning of danger.

Tariq's diagnosis hit me like a brick in the face. It was so hard to believe, that I couldn't get the word "autism" out of my mouth. I was confused and bewildered. And I didn't know which end was up – feeling so bad about the diagnosis, but so good about having this adorable child.

The news awakened in me a grief beyond words... yet, there was no death. In front of me was a totally normal-looking child whom I loved as much as life itself. Were my eyes deceiving me?

The feelings that followed did not come in distinct phases. They were entwined and blurred, but there seemed to be some pattern.

Elizabeth Kubler-Ross first articulated the stages of grief as denial or shock, anger, bargaining, depression or sorrow, and acceptance or coping.

Unfortunately, not everyone who uses these terms understands them. When presented dogmatically, these ideas are not helpful to parents who are struggling to cope. As with any theory, there is a wide range of how people react in everyday life. Real sorrow is not predictable. Your emotions are in turmoil,

running the gamut of fear, shock, anger, guilt, sadness and shame.

Body, mind and spirit reel from the impact. Worst of all, you have no control over the experience.

Grief may hit you when you least expect it. Your child may be making great progress, but still has to go to a special school or be in a special class, or even need special services. On your child's ninth Christmas, it could be tough for you if you are still buying baby toys, as I was, and hoping your child would enjoy them.

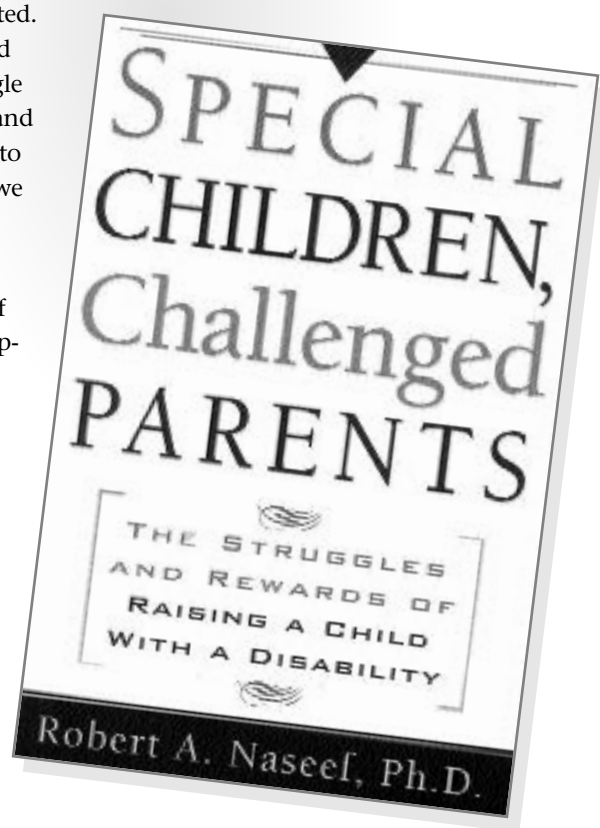
Often, the grief can be for ourselves – that our lives as parents did not turn out how we had expected. Our child may be happy and content while we still struggle to let go of the old dreams and make new ones as we learn to accept and enjoy the child we actually have.

Indeed, as I have come to realize, this is the struggle of all parents, even those of typical children. Who has ever turned out to be the perfect parent of the perfect child? On the other hand, when your child is so far from the norm, your very identity is challenged. While our friends are coaching t-ball or attending dance recitals, we may be learning sign language, giving injections or restraining our children.

Signs of transformation

My inner transformation was reflected in how my dreams evolved over time. When I first knew that something was wrong, but couldn't accept the severity of the problem, I would dream at night of my daily encounters with Tariq. In my dream, I was doing what his early intervention therapists had

Order your copy of Dr. Naseef's book by calling Birch Lane Press/Carol Publishing Group at 1-800-447-BOOK (2665). Or receive a 30 percent discount when you order through www.amazon.com.



Bob and Tariq enjoy running together on a crisp, cool autumn day at Marsh Creek State Park near West Chester, Pennsylvania.



A photo that captures some of Tariq's first wobbly steps just after his first birthday.

recommended: imitating his repetitive movements by flapping my arms when he flapped his. When I would do this in reality, Tariq would usually notice me, stop what he was doing, give me a little smile and then go back to what he was doing. In my frequent dream, Tariq would look at me intently while I was mirroring his behavior, then slowly form a word or two. My heart beating faster, I would rejoice and hug him.

In the morning, I would wake up renewed with the motivation to keep working to make the dream come

true. I would tape record Tariq's grunts, groans and babbling, and listen to them, searching for progress or meaning. At times I even thought I heard some.

But no words came.

Instead of renewed, I began awaking exhausted and overwhelmed. The dream was not coming true! This realization was hard to endure as my hopes faded.

Throughout my life, whenever I had worked hard at something, I had gotten results. When people became sick, they also got better. My parents and my teachers had told me so. How could I think otherwise? I steadfastly refused to believe that I had no control over my child's condition.

As my dreams evolved, everyday life changed forever. Tariq's special needs seemed endless. He rarely slept through the night, and I was constantly exhausted. My boy was – and is – a constant threat to his own well-being. In the few relaxing moments left to me, dreams provided a welcome respite.

Love and hard work weren't enough to change the situation. I cried and cried over these years as the grief washed over me.

Around Tariq's eighth birthday, I had a new dream: my boy spoke to me in sentences. I was overjoyed. However, as the dream continued, I woke up within the dream knowing that Tariq had not spoken.

The next morning I awoke, strangely relieved. I had somehow reached a turning point. A turning point at which I had begun to accept Tariq as he was – and still love him. No longer did I have to keep pushing him or myself. Through dreams, my mind had let me know that having what I thought of as a "normal" son was an unreachable goal. I finally exhaled so many frustrations and took in my first breath of serenity.

“Your joy is your sorrow unmasked...”

A few years later, in a new dream, Tariq looked at me intently with his big brown eyes. He told me that he loved me, felt my love and knew I had done everything possible for him. He told me that he was happy, and wanted me to be. Then he began playing with his tongue and making unintelligible noises, seemingly unaware of my presence unless he wanted something. I felt sorrow and longing for what could have been if only he could have continued talking.

On waking, I had a definite sense that I had moved a little further on my journey. Tariq – with his limitations – was a part of me, and I was a fuller, deeper person because of him. I had survived and healed and was different now.

Tariq had been – and continues to be – a catalyst for a life fuller, deeper and more loving than I had ever imagined. Some of my greatest joys and deepest sorrows have been in the moments he and I have shared. His disability is so severe, but his soul, his inner essence is totally “normal.” Without speaking a word, he has taught the little boy in me to speak. In this way, he is with me at every moment. He has positive and negative emotions, and has taught me

to see them readily in myself and others. There is pride when accomplishing something he set out to do, and a refreshing sense of humor.

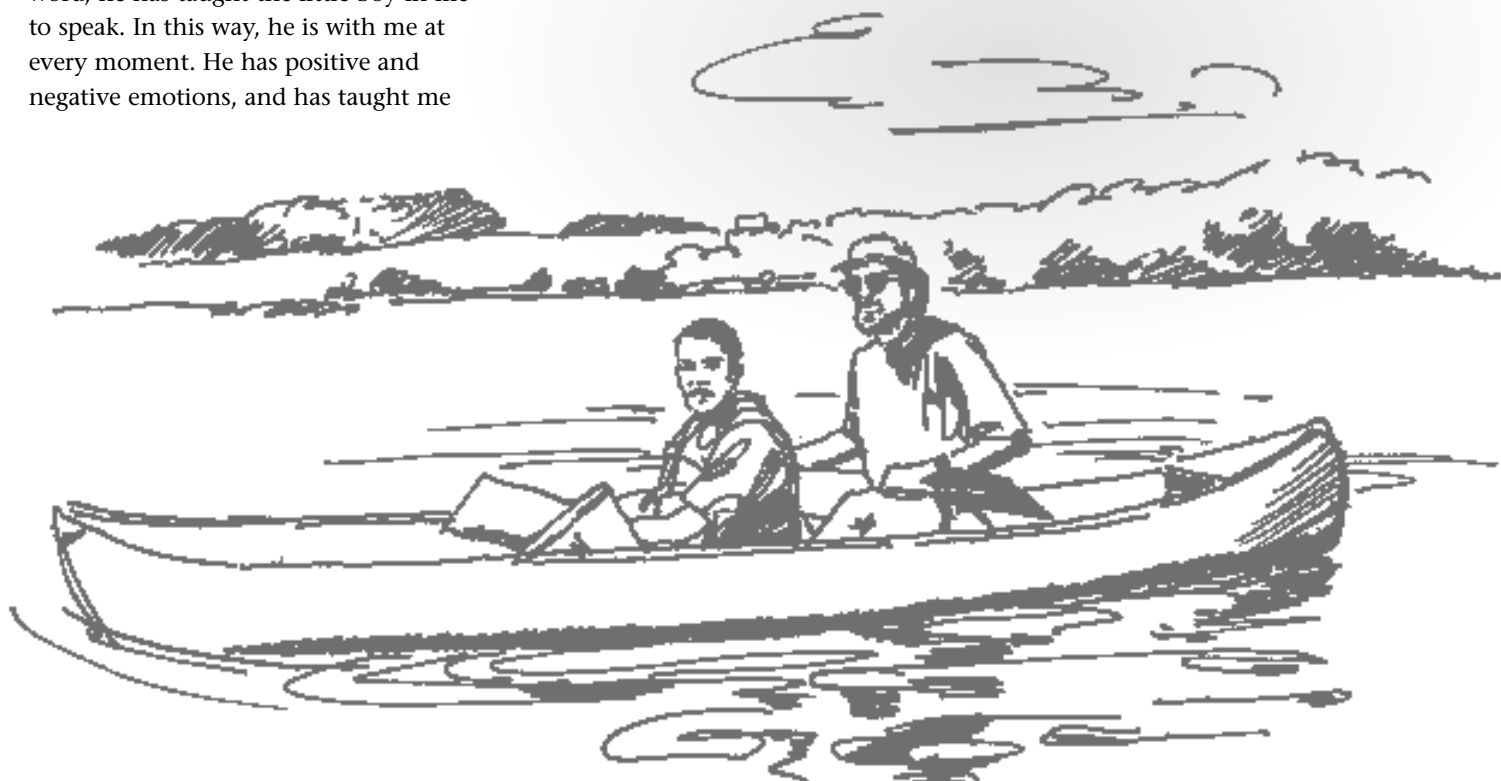
In a world that has valued reason and intellect above emotion, children like Tariq teach us to look inside ourselves. As a thoughtful father told me recently, they are not “children of a lesser God.”

Yet, my struggle to accept such a fate was beyond the understanding of anyone in my life at the time. Although I have raged over how lonely that was, it was not anyone’s fault.

What helps you get through it all?

- When people ask how you are and want to hear the real answer.
- When they ask how they can help – and really want to.
- Meeting people who have been through it.
- People finding value in your child just as he or she is in the moment.
- Kind words and the time to heal your broken heart.

Canoeing is a favorite activity for father and son, alike.



Joy and sorrow may be our soul mates. As Kahlil Gibran, in "The Prophet," wrote, "Your joy is your sorrow unmasked... The deeper that sorrow carves into your being, the more joy you can contain."

The sorrow, although unwelcome, can be a pathway to an unconditional love that grows from the intrinsic beauty of each and every child's existence. We parents of children with disabilities can feel fine about ourselves when we grasp this concept and give up superficial, achievement-based values.

For Tariq, as for most special children, there has been no miracle, despite all my striving and wishes. I am powerless to change him, but he has changed me so much that I have no idea who I would be without him.

I am okay without the baseball and the model airplanes. I did get the close, warm relationship. And a touch of wisdom. No way would I give that up.

Still, there are times when I wish we could sit down and really talk.

Robert Naseef, Ph.D., is a psychologist who lives in the Philadelphia area with his wife, colleague and best friend, Cindy. Their blended family includes three daughters: Antoinette, age 17; Kara, 7; and Zoë, 5. Tariq lives at the Devereux Foundation's Kanner Center in nearby West Chester, Pennsylvania. The story of Dr. Naseef's journey with Tariq and his work with families of children with special needs is told in his book, "Special Children, Challenged Parents: The Struggles and Rewards of Raising a Child With a Disability," published in 1997 by Birch Lane Press/Carol Publishing Group. The book is available through local bookstores, the publisher at 1-800-447-BOOK (2665), or on the Internet with a 30 percent discount at www.amazon.com. Write or call Dr. Naseef at 514 South 4th Street, Philadelphia, PA 19147/(215) 592-1333. E-mail: rnaseef@alternativechoices.com.

Building partnerships: how professionals can connect more effectively with parents

Do you have to be a parent of a child with special needs to connect and empathize with parents of children with mental, emotional and behavioral challenges?

Absolutely not.

But what helps is to be able to look inside ourselves as individuals and touch the feelings of grief that we all inevitably experience. Remember your own major losses – such as with a death, serious illness, divorce or even the disappointments of everyday life. Who amongst us does not struggle with accepting the reality of the imperfect lives we live as partners, parents, teachers, therapists, social workers, psychologists, psychiatrists? Recalling shock, denial, anger, fear, shame, sadness and eventual acceptance can help professionals build therapeutic partnerships with parents.

What are some of the qualities that help clinicians work effectively with parents of children with special needs?

- Respect for the skills and knowledge that parents bring to the process.
- Open and clear two-way communication.
- Understanding and empathy for their individual circumstances.
- Shared planning and decision making.
- Awareness of unique strengths and needs.
- Unconditional positive regard for child and family.
- Respect for differences of opinion.

KidsArt™

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Moving bodies, making art, having fun
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The Family Resource File

Are you a resource for children and families?

If you provide a unique service to children and families, KidsPeace will consider including your listing in "The Family Resource File."
Send information to Janice Curran, Editor, KidsPeace Creative Services, 5100 Tilghman Street, Suite 010, Allentown, PA 18104.
(Space constraints may prevent us from using all submissions.)

American Self-Help Clearinghouse

Barbara J. White, Coordinator, Information Services

Northwest Covenant Medical Center
The Self-Help Clearinghouse
25 Pocono Road
Denville, NJ 07834-2995
(973) 625-9569

<http://www.cmhc.com/selfhelp>

National non-profit organization that maintains a database of over 800 national self-help groups dealing with a wide variety of topics. Also available from the clearinghouse is the "Self-Help Sourcebook: Your Guide to Community and Online Support Groups."

Camp Friendship

George M. Hecht, MD, Camp Psychiatrist and Clinical Supervisor

57 West Main Street
Clinton, NJ 08809
(908) 730-9019

Five-week summer program providing a recreational and therapeutic camp experience for children ages four through 14 with attention-deficit disorder. Parent support groups and follow-up program.

"Drawing Out Feelings"

Marge Heegaard, MA, ATR, LICSW, Author

Woodland Press
99 Woodland Circle
Minneapolis, MN 55424
(612) 926-2665

Series of workbooks designed to provide parents and professionals with an approach to helping children ages six through 12 cope with feelings resulting from family loss and change. Facilitator guide offers suggestions for developing grief support groups and directions for using the art process to help children.

International Network for Children and Families

<http://www.redirectingbehavior.com>
1-800-257-9002

Public, non-profit agency committed to creating – through parent education – new generations of responsible children who have higher self-esteem and better cooperation skills. Courses, workshops, textbooks, tapes (audio and video), on-line resources and scholarships provided.

Paul Alexander's Music and Bereavement Resources

Paul Alexander Productions
PO Box 125
Rockville Centre, NY 11571
1-800-538-4158

Concert and workshop presentations by psychotherapist singer/songwriter and bereavement specialist whose bereavement resources include music and meditation tapes, books and videos.

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