

Resourcing: The Experience of Children Attending
Individualized Tri-Phasic Trauma Therapy

by

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B.Sc.N., University of Victoria,
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Abstract

This study investigated the resourcing experiences of children and youth attending office-based, tri-phasic trauma treatment. Ten participants were recruited from both private and agency based clinical psychology or counselling practices. During semi-structured, in-depth interviews participants described their resourcing experiences. The data were analyzed using the descriptive, phenomenological, and psychological method of Amedeo Giorgi. The results revealed a basic structure in the resourcing experiences of the child participants which was comprised of 12 constituents: (a) perceived attitude of the therapist, (b) personal and contextual relevance, (c) currency, (d) choice and control, (e) calming, (f) unsticking, (g) experiential, (h) triumph, (i) internal ease, (j) needing a guide, (k) naming the resource, and (l) betterment. The findings contribute to an understanding of the resourcing experience of youth in trauma therapy by adding the client's voice to the therapeutic process. Implications for clinical practice and further research are presented.

Keywords: child, youth, trauma, therapy, resource development, resourcing, PTSD, descriptive phenomenological, Giorgi

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Chapter One: Introduction

The past thirty years have seen a dramatic increase in our knowledge of the influence of trauma on children (Gil, 2006) however, the body of relevant literature to date is neither simple nor straightforward: Trauma-related issues for children remain complex (Koenen, Roberts, Stone & Dunn, 2010; van der Kolk & d'Andrea, 2010). Their experience of trauma therapy, and resourcing as a component thereof, has been underinvestigated. As trauma-related research continues to expand, the inclusion of children's voices in the literature on therapeutic resource development is a significant addition that ideally will inform and improve trauma therapy.

To better understand a child's experience of trauma, it is helpful to examine how the concept of trauma is currently defined and interpreted. Trauma, from the Greek word for *wound* (also meaning *damage* and *defeat*), has both a medical and psychological meaning (Webster's New World Medical Dictionary, 2008). Medically, trauma refers to a "critical bodily injury, wound, or shock that overwhelms the body's natural defenses and requires medical assistance for healing" (Koenen et al., 2010, p.13). Psychological trauma may be defined as "a circumstance in which an event overwhelms or exceeds a person's capacity to protect his or her psychic well-being or integrity" (Cloitre, Cohen, & Keonen, 2006, p. 3). Psychological trauma is often used to refer both to overwhelming and distressing events, as well as to the distress itself (Briere & Scott, 2006).

The degree to which a child or adolescent manifests trauma-related symptoms involves a complicated relationship between a number of factors. These factors include

(a) the predisposing characteristics of the child, (b) the characteristics of the trauma, and (c) variables relating to posttrauma (Briere & Scott, 2002; Gil, 2006).

Some, but not all, children who experience trauma develop clinical symptoms. Other children may also experience symptoms of distress, but are considered non-clinical because their symptoms do not meet current diagnostic criteria for Posttraumatic Stress Disorder (PTSD; Pearce & Pezzot-Pearce, 2007). The current diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) sets out the criteria for a diagnosis of the Anxiety Disorder, PTSD. The DSM-IV-TR lists six criteria for this diagnosis (See Appendix A for the full diagnostic criteria) of which four are particularly relevant in the context of children and trauma.

Following exposure to a traumatic stressor, Criterion A specifies that a child must demonstrate both of these conditions; (a) the individual must have experienced, witnessed, or been confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (Criterion A1), and (b) the individual must have responded with intense fear, helplessness, or horror (for children this may appear as disorganized or agitated behavior; Criterion A2). Significantly for children, traumatic experience includes “developmentally inappropriate sexual experiences without threatened or actual violence or injury” (APA, 2000, p. 464).

Criterion B deals with the persistent reexperiencing of the traumatic event. Reexperiencing may occur in several ways with at least one of the following being

present: dreams, flashbacks, distress arising from reminders of the event, and psychological reactivity to cues resembling some part of the event.

Criterion C addresses the persistent avoidance of something (e.g., people, locations, activities, thoughts, feelings, or interactions) which serves as a reminder of the trauma or is somehow associated with the traumatic event.

Criterion D refers to the posttrauma symptoms of persistent and increased arousal. These symptoms present as sleep disturbances, mood fluctuations (including outbursts of anger), attentional difficulties, hypervigilance, and an exaggerated startle response.

The DSM diagnosis for PTSD first appeared in the 1970s to accommodate the “pathology of the hundreds of thousands of returning Vietnam veterans” (van der Kolk & d’Andrea, 2010, p. 57) due to an awareness of the difficulty in developing effective treatments without a formal diagnosis. With the introduction of the PTSD diagnosis, research in the area expanded dramatically. Researchers and clinicians quickly discovered that the PTSD studies were relevant to victims as diverse as those experiencing rape, or torture, or earthquakes or even motor vehicle accidents (van der Kolk & d’Andrea, 2010).

Now sensitized to the sequelae of traumatic experience, clinicians found that those exposed to the chronic victimization of betrayal, abandonment and abuse by their caretakers suffered a similar symptomology. In fact, such psychological traumas often caused a vastly more complex set of psychobiological disturbances than those resulting from the trauma of earthquakes or motor vehicle accidents (Herman, 2009). For these

more complicated and chronic stress related conditions, Courtois and Ford (2009) provided the following definition:

We define complex psychological trauma as involving stressors that (1) are repetitive or prolonged; (2) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; (3) occur at developmentally vulnerable times in the victim's life, such as early childhood; and (4) have a great potential to compromise severely a child's development (p. 1)

Complex Traumatic Stress Disorder, or Complex PTSD (Courtois & Ford, 2009), although outside the formal diagnosis of PTSD, nonetheless appears prominently in the literature on trauma.

In addition to recognizing that trauma in childhood does not necessarily require the child to experience a direct threat to his or her life or physical integrity, several authors have suggested that certain life events could be sufficiently distressing so as to constitute a traumatic experience (Briere & Scott, 2002; Courtois & Ford, 2009). The sudden or unexpected loss of a parent or loved one (including a pet) is an example of such a potentially traumatic event.

Recently, The National Child Traumatic Stress Network (NCTSN) DSM-V Task Force¹ initiated a proposal for a new classification of trauma disorder that goes beyond the restrictive *DSM-IV-TR*'s (APA, 2000) definition of trauma. The proposed *Developmental Trauma Disorder*, based on three decades of research into the effects of

¹ This task force is co-chaired by Bessel van der Kolk and Robert Pynoos and includes Bradley Stolbach, Julian Ford, Joseph Spinazzola, Marilyn Cloitre, Alicia Lieberman, Glenn Saxe, Frank Putnam, Dante Cicchetti, Martin Teicher and Wendy D'Andrea.

childhood betrayal, abandonment, and abuse, is intended to specifically encompass the symptoms suffered by victims of childhood interpersonal trauma (Pynoos et al., 2009; van der Kolk & d'Andrea, 2010).

Courtois and Ford's (2009) definition of complex PTSD reflects the NCTSN task force's suggestions for change to the DSM. Both Briere and Scott (2006) and Cloitre et al., (2006) have further described trauma as a clash between events or circumstances and a person's resources. Trauma results when the power of the event is greater than the resources available for an effective response and recovery. This imbalance can be temporary or persistent.

Cloitre et al., (2006) elaborated that, in these situations, "deterioration in functioning occurs, and intervention or resources beyond those the individual has available are required for recovery"(p. 3). Therefore in keeping with the expanded definition suggested by these authors, a broader description of trauma and traumatic experience is used herein as the basis for conceptualizing traumatic stress.

There is an arguable distinction between experiencing trauma and being traumatized. Currently, depending on the study and type of trauma, between 20 - 30% of children exposed to traumatic events are thought to experience PTSD (Fairbank, Putnam, & Harris, 2007; Koenen, et al., 2010; Saxe, MacDonald, & Ellis, 2007). These rates are nearly double those reported in adult populations (Christopher, 2004; Friedman, Keane, & Resick 2007). If abused children are included with the sample, the incidences of PTSD diagnoses rise to 42-90% in sexual abuse cases, 50-100% in child witnesses of domestic violence incidents, and as high as 50% in samples of children who have been

physically abused (Beers & De Bellis, 2002). Again the wide variance in rates reflects, not only different studies and sample populations, but the complexities and confusions that currently surround trauma diagnosis and treatment in children.

De Bellis (2001) noted that a more complete picture emerges when researchers examine both the rates of abuse for children within the mental health system as well as the rates for those who are non-referred, a phrase that they defined as denoting a child who was not clinically referred within 60 days of reporting abuse or neglect, or witnessing violence. For children who do not reach the mental health system, the rates of PTSD are thought to be lower, though still concerning, at 39% in a sample of abused and neglected individuals and 36% in non-referred sexually abused young children (Pearce & Pezzot-Pearce, 2007).

There are many approaches to working with children who have experienced trauma. Most research into psychotherapeutic treatment investigates adult responses to intervention, often in laboratory settings (Briere & Scott, 2006; Cloitre et al., 2002; Foa, Keane, & Friedman, 2000; Friedman, et al., 2007; Korn & Leeds, 2002; Lawler, Ouimette, & Dahlstedt, 2005; Mayo, 1948; Polusny et al., 2008). Current research on trauma intervention for children and youth is very limited. However, an examination of current clinical practices provides a helpful framework for understanding the experiences of traumatized youth as they intersect the mental health system (Ford & Courtois, 2009; Silberg, 2000; van der Kolk & d'Andrea, 2010).

Many therapists employ a phasic approach when working with traumatized children or adults (Cloitre et al., 2006; Herman, 1992; Loewenstein & Welzant, 2010; Marmar &

Horowitz, 1988; Terr, 2008; Tinker & Wilson, 1999; van der Hart, Nijenhuis, & Steele, 2006). Typically, a phasic approach encompasses three phases of trauma intervention: Safety and Stabilization, Reprocessing Events and finally Reintegration (van der Hart, Brown, & van der Kolk, 1989).

Resource development, or *resourcing* as it is referred to by many clinical practitioners, is an integral component of these phasic approaches. Ogden, Minton and Pain (2007) described resources within the treatment process as “all the personal skills, abilities, objects, and services that facilitate self-regulation and provide a sense of competence and resilience” (p. 207). Turner and Diebschlag (2001) add

...in the context of trauma work, resources are those awarenesses, abilities, objects, energies, and connections that support a person not only in surviving, but also in maintaining a sense of inner integrity and relationship in the world, a sense of one’s ‘place in the family of things (p. 77)

For many therapeutic disciplines the specifics of the application of the term *resourcing* are highly dependant on the treatment modalities and individual client requirements. An expanded discussion of resources is provided in the following section, but there is no definitive and clear description of *resourcing*, beyond the obvious and general description (i.e., the development of resources) in the available research and clinical literature. In addition to the lack of a universally accepted definition for *resourcing*, the current paucity of knowledge regarding how children report that they experience resource development in trauma therapy, has the effect of under-appreciating children as the experts on their own experience. Instead, there is an emphasis on practitioner interpretations. Although these interpretations may lead to positive outcomes in some cases, they also have the

potential to lead to misguided, irrelevant, and possibly harmful interventions (Dishion, McCord, & Poulin, 1999; Pan & Bai, 2009; Read, Hammersley, & Rudegeair, 2007; Regehr & Glancy, 1997; Shirk, 1999).

The primary focus of this inquiry therefore, is on the exploration of the resourcing experience of children attending individualized, tri-phasic trauma therapy. The intention is to begin to address the dearth of current knowledge about the experience of resourcing from the child's perspective. By providing a psychological description of the basic structure of the resourcing experience from the child's point of view, the hope is that the information generated from this exploration will inform and enrich clinical practice for children in trauma therapy.

The remaining pages of this introduction provide a brief overview of trauma and traumatic stress in children and the related therapeutic models in order to place the concepts and their applicability in context. Chapter Two is a critical review of the literature on resourcing and discusses some important aspects of general therapeutic work with children. Chapter Three explores methodological considerations and the research process for this inquiry. Chapter Four presents the findings of the data analysis; and, finally Chapter Five examines the implications of this study for clinicians and researchers.

Background – Children, Trauma, and Therapy

Trauma and traumatic stress in children. An understanding of the types, impact, and implications of traumatic stress in children assists in contextualizing the necessity to target this population with concentrated research and therapeutic efforts.

Children and adolescents experience two general types of trauma (Cloitre et al., 2006; Stien & Kendall, 2004; van der Kolk & d'Andrea, 2010). The first type of trauma is termed acute and is reflective of a single incident. Acute, single incident trauma involves: (a) personally experiencing a serious injury or witnessing a serious injury or death (b) facing imminent threats of serious injury or death to self or others, or (c) experiencing a violation of personal physical integrity. These experiences are traumatic when they evoke overwhelming feelings of terror, horror, or helplessness (APA, 2000). Examples of this type of trauma include: natural disasters, serious accidents such as vehicle crashes, the sudden or violent loss of a loved one, or physical or sexual assault by a stranger.

The second kind of traumatic experience involves repeated and chronic exposure to trauma. Such experiences evoke intense feelings of fear, loss of trust in others, a reduced sense of personal safety, as well as feelings of guilt and shame. This kind of trauma is also referred to as complex, relational, or interpersonal trauma. Examples of this kind of traumatic situation include: on-going physical abuse, multiple incident sexual abuse, domestic violence, and chronic exposure to political violence, war, and even chronic illness.

Traumatic stress is the physical and psychological manifestation of distress in response to one of the two types of trauma. The National Child Traumatic Stress Network (NCTSN; 2011) states that traumatic stress in childhood occurs when children have experienced an overwhelming event or series of events that render them helpless or powerless, create a threat of harm and/or loss, and cause an internalization of the experience that continues to influence their perception of self, others, the world, and the

children's own development. Age and stage of development play a role in the traumatic stress response, as the age of the child at the onset of the traumatic experience, and a history of previous or repeated exposure to trauma, will intersect with the child's coping strategies, which are often stage-specific (van der Kolk & d'Andrea, 2010). Through the accumulation of life experience, a ten-year-old child responds differently to traumatic situations than a five-year-old child, who is less able to articulate his or her needs in such situations.

Furthermore, the successful or incomplete mastery of a developmental task will influence the manifestations of traumatic stress. A child who has not gained a sense of trust toward caregivers may face greater challenges when he or she struggles to develop therapeutic relationships with adult therapists. On the other hand, a child who has experienced attentive and reliable caregivers, who then suffers the traumatic loss of one of those caregivers, may be better positioned, developmentally, to collaborate with adult therapists and work toward a resolution of the loss.

Many children who experience trauma will show signs of intense distress such as anxiety, disturbed sleep, difficulty paying attention and concentrating, anger and irritability, withdrawal, repeated intrusive thoughts, and nightmares (van der Kolk & d'Andrea, 2010). Symptoms of distress often appear when children are confronted with reminders of their traumatic experience. Such trauma-induced distress often leads to cycles of physiological arousal and the emotional dysregulation of the child's nervous system (e.g., mood swings, behavioral outbursts etc.).

Physiological arousal occurs along a continuum from hypoarousal, with its lack of energy, to hyperarousal, which demonstrates excessive energy (Ogden et al., 2007). Such extremes of physiological arousal manifest from the slowed, almost motionless appearance of a catatonic state, all the way to the rapid heart and breathing rates of a panic attack.

Often accompanying the physiological symptoms are rapid fluctuations in affective states, or emotions. When compared to adults, children experience quick shifts in emotion even in normal circumstances. For instance, a child could be playing happily on the school ground, and the next minute become angry when another child jumps the queue for a turn on the swing. Children with a history of traumatic experience may exhibit more rapid and intense cycles of emotion, having relatively limited skills to self-regulate their emotional responses (Hannesdottir & Ollendick, 2007; LaFrenier, 2005; Pfeifer, Iacoboni, Mazziotta, & Dapretto, 2008).

Repeated exposure to traumatic events can influence the development of a child's brain and nervous system, causing changes in neurobiological formatting, neurochemistry and neurotransmitter networks, and a dysregulation of functionality with resultant anxiety, impulsivity, mood disruptions, hyperactivity, and sleep disorders (Bremner, 2005; Dapretto et al., 2006; De Bellis, 2010; De Bellis, Hooper, & Sapia, 2005; Glasser, 2000; Porges, 2006; Teicher et al., 2010). Impaired neurological development may increase the risk of compromised academic performance, engagement in high risk behaviours, and persistent difficulties in relationships with others.

Children's responses to traumatic experience can range from attentional, behavioral, and emotional problems to overt psychiatric disorders such as posttraumatic stress disorder, depression, and anxiety (van der Kolk & d'Andrea, 2010). Some clinicians/researchers also consider other conditions such as attachment, personality, and substance-use disorders as having a strong relationship to childhood traumatic experience (Cohen, Mannarino, Zhitova, & Capone, 2003; Ogden et al., 2007; van der Kolk & d'Andrea, 2010).

Many children "bounce back" from adverse experience. However, children who have experienced overwhelmingly traumatic situations are vulnerable to a significant disruption of normal child or adolescent development (Stien & Kendall, 2004). They are more likely to enter both the medical and mental health care systems (Briere & Scott, 2006; Browne & Winkelman, 2007; Eytan, Toscani, & Loutan, 2006; Hankin, 2005; van der Kolk & d'Andrea, 2010). The personal cost as well as the cost to society's health care and social support systems is enormous, hence the earlier and more comprehensive the interventions the better. Resource development represents a component of a long-term solution to a plethora of problems that derive from exposure to traumatic events.

Children and adolescents, especially those who endure chronic types of traumatic experience, are also over-represented in child welfare and protection services (Felitti & Anda, 2010; NCTSN, 2011) and the juvenile-justice systems (Briere & Scott, 2006; Fairbank et al., 2007; Fisher & Gunnar, 2010; Paton, Crouch, & Camic, 2009; van der Kolk & d'Andrea, 2010). Furthermore, long-term indicators suggest that these children are likely to suffer some of the negative physical and psychological effects of post-traumatic stress well into adulthood (Bremner, 2005; Diehl & Prout, 2002; Fairbank et

al., 2007; Felitti & Anda, 2010; Glasser, 2000; Silberg, 2000). Therefore, as adults, survivors of earlier traumatic experience may struggle to establish fulfilling relationships, maintain steady employment, and become active, productive members of society.

Anything that can be done to ameliorate the effects of trauma in children has long term positive implications to the future adult populations intersecting the mental health and medical systems.

Therapeutic Approaches. After decades of research on posttraumatic stress, the disciplines of clinical and counselling psychology have accrued a rich literature on working therapeutically with trauma survivors in individualized clinical practice (Cohen, Berliner, & March, 2000; Fairbank et al., 2007; Foa et al., 2000; Friedman et al., 2007). Traditional therapeutic approaches typically arose out of theoretical orientations, such as psychodynamic or humanistic theories (e.g., psychoanalysis, behaviorism, and the therapies of Carl Rogers and Abraham Maslow) and were applied to adult trauma survivors. These approaches have only recently been used with traumatized children (Silberg, 2000; Terr, 2008). Other therapeutic approaches have emerged and been further categorized based on the modality of treatment (e.g., play, expression, art, drama, movement, talk, mindfulness, experience, and information processing; Cohen et al., 2000).

Clinicians have developed models, or overarching frameworks, for how to conduct therapy for each specific approach (e.g., EMDR, Sensorimotor Psychotherapy). These models incorporate aspects of various theoretical orientations as well as treatment modalities (i.e., the way in which the therapy is delivered) for the management of a full spectrum of traumatic reactions. These reactions range from the insidious and pervasive

challenges (i.e., difficulty establishing or maintaining relationships or holding down jobs) that permeate the psychology of people who have been traumatized, and which impact their relationships and their ability to cope and function within their environments, to the more overt symptoms of PTSD (i.e., experiencing a flashback and diving under a table during a dinner party because someone dropped a tray which made a clanging noise).

Since there is such a wide variety in the expression of trauma reactions, an equally diverse array of therapeutic models is currently available to the practicing clinician. These approaches include, (a) several Cognitive-Behavioral Therapies (CBT's) and most commonly Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Foa & Rothbaum, 1998; Friedman et al., 2007), (b) Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001), (c) Sensorimotor Psychotherapy (Ogden et al., 2007), (d) Traumatic Incident Reduction (TIR; Gerbode, 2006), and (e) Critical Incident Stress Debriefing (CISD; Mitchell, 1983). The sheer volume of therapeutic approaches and variations thereof is beyond the scope of this dissertation; however it must be noted that there are far more than those listed here.

Frequently, therapeutic approaches to trauma tend to be adapted for work with specific populations, reactions, and/or conditions. Those adapted for working specifically with children include TF-CBT, (Cohen, et al., 2000; Feather & Ronan, 2006), Emotion-Focused Cognitive Behavioral Therapy (Suveg, Kendall, Comer, & Robin, 2006), EMDR (Adler-Tapia & Settle, 2007; Greenwald, 1999; Lovett, 1999; Tinker & Wilson, 1999), and CISD (Stallard & Salter, 2003; Wraith, 2000). Personally, in my own consultation groups, I have also encountered therapists who have created hybridized approaches by combining sets of techniques from a variety of models for use with their child clients.

Despite the wide variety of therapeutic approaches, for both children and adults, the field of clinical traumatology has largely incorporated Pierre Janet's (1924, 1930) three-phase treatment model (Briere & Scott, 2006; Cloitre, Keonen, Cohen, & Han, 2002; Cohen et al., 2000; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Hannesdottir & Ollendick, 2007; Herman, 1992; Korn & Leeds, 2002; Loewenstein & Welzant, 2010; Marmar & Horowitz, 1988; Mayo, 1948; Ogden, et al., 2007; Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005; Veith, 1965). The three phases that Janet (1924) proposed are (a) Safety and stabilization, (b) Processing of traumatic memory and, (c) Re-integration.

Janet (1924) emphasized resource development during the first of the three phases: safety and stabilization. In this phase, the therapeutic development of a client's resources is used to manage the symptoms of traumatic reaction, reduce the risk of re-traumatization from reminders of the traumatic experience, and as preparation for trauma processing (Chemtob, Nakashima, & Carlson, 2002; Janet, 1924; Marmar & Horowitz, 1988; Ogden et al., 2007). However, efforts to discover, identify, and develop a person's internal and external resources and bolster existing resources are identified as valuable interventions at all stages of trauma treatment (Janet, 1924; Ogden et al., 2007, Turner & Diebschlag, 2001; van der Hart, et al., 2006). Janet's contribution is explored in more detail in the section: Foundations of the Tri-Phasic Approach to Trauma Treatment and Resourcing.

In order to narrow the focus of my inquiry, this dissertation concerns itself specifically with the psychotherapeutic approaches and the resourcing components thereof, which have evolved from Janet's practice and writings.

Statement of Purpose

The intention of this study was to explore the experience of resource development, or resourcing as it is commonly called in the field of trauma therapy, from the perspective of the children themselves, as they attended individualized tri-phasic trauma therapy. My hope was that an expanded understanding of children's experiences of resource development would enable practitioners to better collaborate with children in their care to maximize the efficacy of their treatments. In the interest of guiding this exploration, I proposed the following research question:

What is resourcing as experienced by children attending individualized trauma therapy?

The Researcher – My Background and Context

At the time of writing, I maintain a private practice as a trauma therapist. I am also involved in the field of trauma therapy as a consultant, clinical supervisor and educator for other trauma professionals. I bring to the inquiry process, not only my practical experience as a therapist working with traumatized children in a clinical setting, but also the extensive theoretical knowledge of a consultant and educator.

I have been mindful since the outset of the study that there is a possibility that the same background that provides me with a dual and valuable insight into the field, might conceivably encourage a potential bias in my perspective on therapy-related decisions such as resourcing interventions. In order to counter this potential bias, I began by explicitly acknowledging my assumptions and theoretical orientation at the outset of the study. I further committed to engaging in an ongoing critical reflection by way of

journaling and I maintained an ongoing dialogue with professional colleagues and advisors in order to minimize bias-related perspectives, issues and concerns.

Personal Rationale and Significance – Hurt People Hurt People

After many years in trauma-related mental health practice, I have come to appreciate traumatic experience from a number of different perspectives, which include those of the perpetrator, victim, family, community, system, helper and therapist. After 8 years of working in forensic settings, I came to increasingly support the adage that *hurt people hurt people*.

The majority of my patients who had traumatized others had significant trauma histories themselves. In addition, the effects of their trauma histories were often perpetuated directly or indirectly by well-meaning but poorly-informed treatment facilities. Further traumatizing a traumatized individual encourages additional reactive behaviors. I saw first hand, that children with adverse traumatic experiences were at risk to continue cycles of violence, abuse, and neglect by reacting to the unresolved effects of their own childhood traumas as they grew to adulthood.

I observed that such cycles were not unique to forensic populations when I worked as a general nurse on emergency, pediatric, and general medical and surgical wards. It was clear that the effects of adverse experience and trauma also afflicted the general population. My observation that such adverse effects appeared to be related to early experience and relationships motivated me to pursue a Master's degree in Learning and Development with a special interest in Developmental Psychopathology, Resilience and Vulnerability. I applied my education to a developmental approach to trauma therapy

with the hope that early and developmentally sensitive intervention would help return a client to a healthier developmental path.

This study emerges from my ongoing desire to uncover ways to effectively and efficiently resource traumatized children. More effective resourcing, either in preparation for trauma processing or to assist in overcoming blocks, or what I call *stuckpoints*, during that trauma processing, should better assist the client in achieving a more normative developmental trajectory.

I believe that an improved understanding of children's perspectives on resourcing will provide valuable information to better inform and improve trauma therapy practice. Such understanding begins with an exploration of the "what-ness" and "how-ness" of resourcing itself. Thereafter, the addition of the voice of the child-clients may shed light on what needs to happen, and in what ways, for therapists to better help traumatized children to alleviate their suffering and thereby return them to a less encumbered developmental path.

Chapter 2: Literature Review – Resourcing in Child Trauma Research and Therapy

Search Parameters

I conducted a broad literature search using the University of Victoria's electronic search engines, Web of Science, PsychINFO, and Academic Search Complete. I completed multiple Boolean keyword searches using the following search terms: PTSD, resources, resourcing, trauma, traumatic stress, intervention, approaches, and therapy, combined with the terms children, adolescents, and youth.

Further, I refined my searches using several resource-encompassing terms, which I gleaned from the literature on PTSD including, psychoeducation, coping skills training, affect tolerance, emotional competence, emotion/affect regulation, arousal modulation/regulation, stress management, mastery experiences, relaxation skills training, cognitive coping, and resource development. In addition to the electronic sources, I consulted several clinical training manuals to complete this review.

Initially, I directed my search of the current literature toward locating definitions, descriptions, and practical applications of resourcing as part of trauma intervention. Thereafter, I searched for empirical research on resourcing children in trauma therapy before moving to the available clinical literature.

The literature review revealed: a) a problematic use of terminology, as few authors define or describe resourcing, b) that research on resourcing is limited for adult populations and virtually non-existent for children and youth, and c) that direct information regarding children's resourcing experiences is elusive. Wherever possible,

research regarding children is provided and where it is lacking, I have included relevant research with adult populations.

Pierre Janet: Foundations of the Tri-Phasic Approach to Trauma Treatment and Resourcing

Currently there exists an obfuscating array of therapeutic approaches to trauma treatment and each is accompanied by its own definitions and criteria. The French philosopher/psychologist/physician Pierre Janet (1924, 1930) originated the use of resource development, now commonly called resourcing, in trauma therapy. His work has been incorporated quite broadly into the active practice of clinical traumatology across disciplines (Briere & Scott, 2006; Cloitre et al., 2002; Cohen, Berliner, & March, 2000; Ford et al., 2005; Hannesdottir & Ollendick, 2007; Herman, 1992; Korn & Leeds, 2002; Loewenstein & Welzant, 2010; Marmar & Horowitz, 1988; Mayo, 1948; Ogden, et al., 2007; Saxe et al., 2005; Veith, 1965).

Janet figures prominently not only in the theoretical conceptualization of traumatic experience and its resultant effects, but also in therapeutic interventions of which the practice of resource development is a key component. The lexicographic development of the term resourcing is obscure, however, it is currently in common usage in the field of trauma therapy as a verb formed from the noun ‘resource’ wherein it has come to refer to the development of a client’s resources as an aid to recovery and processing in trauma therapy.

During his meticulous observation of traumatized patients, Janet saw a decline in their capacity to deal with many stressors unless they engaged in specific actions that allowed

them to gain mastery over their inability to act in satisfying ways (Veith, 1965). Janet accounted for this decline as the continued depletion of energy because of the subconscious activity around the focus of the trauma. These patients' ability to cope, adjust, and adapt was worn down until they were reduced to a state of chronic helplessness, expressed both psychologically and somatically (Janet, 1924).

Janet (1924) initially proposed several important theories to explain how traumatic memories develop and how clinicians might help their clients move beyond trauma. Van der Hart, Brown, and van der Kolk (1989) discussed three major *themes* in Janet's work, (a) a theme encompassing sensory perceptions, mental integration, and memory storage; (b) dissociative reactions as failures of information processing; and (c) psychotherapeutic interventions.

Janet (1919, 1925) considered that psychological trauma resulted from events during which active defensive actions were interrupted, ineffective, or unsatisfactory (Ogden, Pain, & Fisher, 2006; Scaer, 2001; van der Hart et al., 1989). In such events, the person was not able, for a variety of physical, psychological, or social reasons, to actively flee or fight, and therefore either passively froze or submitted.

Although freezing or submitting may be the best option to ensure survival at the time of an event, Janet (1901, 1924) contended that those who employed active defenses did not suffer as did those who resorted to passive defenses. He proposed that in such situations, the traumatic event overwhelmed a person's ability to integrate sensory information, resulting in a fragmentation of the self into parts. Janet called this process of fragmentation structural dissociation of the personality (van der Hart et al., 2006).

At the simplest level, which he termed primary structural dissociation, Janet (1919/1925) conceptualized that one part of the self contained the traumatic experience (including the sensory and emotional reactions) outside of the person's conscious awareness, and another part of the self kept up the appearance of everyday functioning. Janet's dissociation was a removal, from the conscious mind, of the part of the self that experienced the trauma, as an adaptive reaction to traumatic events (Bromberg, 2011). In other words, Janet proposed that a person experienced all of his or her reactions to trauma as "not-me" and thus that "not-me" part of the self was sequestered in the unconscious, only to be reactivated with each reminder of the trauma. Janet's theory of dissociation, along with his tri-phasic approach to treatment, began to re-surface in the 1980s (Herman, 1992; van der Hart et al., 1989), after a lengthy period of neglect.

Janet (1919/1925, 1924) proposed a psychotherapeutic approach to treating traumatic stress that consisted of the following stages: "(1) Stabilization, symptom-oriented treatment and preparation for liquidation of traumatic memories, (2) Identification, exploration and modification of traumatic memories, (3) Relapse prevention, relief of residual symptomatology, personality reintegration, and rehabilitation" (van der Hart et al., 1989, p. 3).

The first phase of Janet's therapeutic intervention, which he called stabilization, consisted of removing the patient from the stressful stimulus, often the patient's family, and thereafter providing a non-stressful environment where the patient was absolved from the immediate responsibilities and pressures of daily life (Janet, 1924). During this time Janet attended to the patient's diet, sleep, and activity levels while he focused on symptom management.

Also during this first phase of care, Janet (1919/1925, 1924) paid particular attention to the therapeutic relationship and the development of rapport. Although the word rapport has come to be more or less synonymous with therapeutic alliance, Janet used it in a manner closer to what is currently referred to as transference. Transference is a psychoanalytic term that refers to a reproduction of emotions relating to repressed experiences, especially from childhood, and the substitution of another person for the original object of the repressed impulses (Bromberg, 2001; Ogden et al., 2007; van der Hart et al., 1989).

Janet considered rapport to be both a symptom of illness as well as a means to a cure (van der Hart et al., 1989). In terms of rapport being a symptom of illness, Janet theorized that transference was a resistance that perpetuated feelings of helplessness and therefore allowed the patient to develop a pathological fixation on the therapist. He opined that a cautious and diligent therapist could capitalize on the phenomenon of transference for the benefit of the patient. Janet's view was that the patient-therapist relationship deserved special recognition and asserted that rapport could be used "to foster the patients' independent actions rather than lead to excessive dependency and misdirected passions" (van der Hart et al., 1989, p.2).

Following the initial period of stabilization, Phase Two focused on reprocessing memories of traumatic events. Janet engaged the patient in psychological analysis, using hypnosis as a method of identifying, exploring, and modifying traumatic memories from the person's "subconscious" (van der Hart et al., 1989). Alternative perspectives, which Janet referred to as substitutions (van der Hart et al., 1989), were then proposed to reframe the patient's experience.

Following the development of substitutions, Janet directed the patient in methods of coping that included a regime of purposeful activity of increasing complexity, such as the progression from dressing oneself to working in a garden (Veith, 1965). The hope was that the patient's symptoms would abate during Phase One and Two of treatment to a significant degree prior to proceeding to the Phase Three stage of reintegration.

The goal of this final stage was to "complete the assimilation of the event" (Janet, 1919/1925, p. 681). Reintegration assumed sufficient resolution of the traumatic material such that the recall of the event was no longer overwhelming. Janet (1919/1925) proposed that there would be a concurrent decline in dissociative symptoms.

For Janet (1924), the assimilation of traumatic material was a necessary but insufficient step in the complete resolution of a patient's reactions to traumatic stress. Janet (1901) observed in his patients a propensity for dissociation in the face of subsequent threat, thus rendering them susceptible to relapse. When a relapse occurred, his prescribed treatment was a return to the stabilization methods of the first phase. This was then followed by the use of hypnosis, as well as purposeful activity designed to increase the patients' mental energy, recover lost functions, and acquire new skills (van der Hart et al., 1989).

In the final phase of his treatment approach, Janet addressed prevention of relapse, reintegration of the personality (i.e., the merger of the part that holds the traumatic experience with the rest of the patient's personality), and the management of any residual symptoms (van der Hart et al., 1989). He considered that a successful recovery resulted

in the achievement of the ultimate treatment goal, which was the resumption of asymptomatic, independent, and productive living.

To achieve this ultimate treatment goal, Janet (1924) promoted the use of a patient's resources. Resource development has been an integral aspect of phasic trauma treatment since the late 1800s (Janet, 1924; Mayo, 1948). The first explicit use of the concepts of resourcing or resource development, in the clinical literature appears in 1889, in Janet's volume, *L'Automatisme psychologique* (he did not coin the word resourcing however, since his material was never translated into English). Later, Janet (1924, p. 296) characterized the completion of appropriate action(s), which he described as being "physically, socially, psychologically finished," as "acts of triumph" and theorized that the "discovery of pleasure" was paramount to both stabilization and recovery.

Janet (1924) promoted methods of education along with the practices of body awareness and integrated physical action. He stated that "...it is not a question of fortifying the nervous and mental activity, of creating new resources, it is simply a question of making use of resources that the subject already possesses" (p. 259). Janet (1924) saw resource development as key in interventions that may "disentangle the patient from that upon which he is stuck" (p. 279) and thus help alleviate, or ideally eliminate, symptoms experienced by people with trauma reactions.

Janet's (1924, 1930) tri-phasic approach as well as his conceptualization of resources and resource development, now widely termed resourcing, as critical to a full patient recovery, continue to be advocated by practitioners in the field of clinical traumatology (Briere & Scott, 2006; Hannesdottir & Ollendick, 2007; Loewenstein & Welzant, 2010;

Marmar & Horowitz, 1988; Ogden, et al., 2007; Saxe et al., 2005). Janet's conceptualization of resourcing provides the basis for the continued modernization of the application and interpretation of the idea.

Resourcing and the Problem of Approach-Specific Language

Janet (1924, 1930) developed the concepts behind the application of resource development in trauma therapy. However, modern discussion, revision, and application of these concepts are fraught with complexities and confusion. The use of jargon in the field of trauma therapy is commonplace, with each treatment modality adopting its own vernacular.

The concept of resourcing is also not immune to approach-specific terminology, definition, and understanding. For instance, Cognitive Behavioral (CBT) therapists might speak of thought stopping, progressive relaxation, or cognitive coping (Cohen, Mannarino, Berliner, & Deblinger, 2000; Feather & Ronan, 2006; Foa & Rothbaum, 1998). On the other hand, Eye Movement Desensitization and Reprocessing (EMDR) therapists collectively understand the Adaptive Information Processing (AIP) model, Safe Place, and Resource Development Installation (RDI; Korn & Leeds, 2002; Shapiro, 2001). See Appendix A for a glossary and Appendix B for a brief description of some common treatment approaches to trauma.

Although it sometimes appears that different approaches are referring to similar concepts, there may be subtle yet important differences. For example, cognitive distortions and negative cognitions are terms that may superficially appear close enough in meaning, however, cognitive distortions are one of at least 10 logical fallacies common

to irrational thinking (e.g., [a] all or nothing thinking, [b] overgeneralization of isolated cases, [c] a mental filter focusing almost entirely on the negative while ignoring or excluding other positive aspects).

A negative cognition, to an EMDR therapist, is a presently held, irrational, self-referencing belief that comes to mind when a person focuses on the disturbing memory of a traumatic event. It is not what the person thought at the time of the original event and need not necessarily be believed, or acted upon, all the time. Importantly, a negative cognition is a description that is not, even possibly, a true description (British Columbia School of Professional Psychology; BCSP, 2008).

Despite the fact that both of these concepts deal with ways that traumatized clients may think, they are understood and applied within the specific context of their respective therapeutic approaches. Similarly, difficulties may also arise when different labels are used to reference what is fundamentally the same technique. A resourcing example of this occurs with the practical applications of the concepts of cognitive restructuring in CBT and the cognitive interweave in EMDR.

Cognitive restructuring refers to the process of learning to refute cognitive distortions. The cognitive interweave refers to strategies to elicit information vital to stimulating a blocked cognitive process while the therapist “stitches” the adaptive cognitive information into the client’s trauma-focused thought processes (Shapiro, 2001). The actuality of the therapeutic processes, as they are applied, both rely heavily on resourcing to accomplish similar, if differently labeled, ends.

It becomes increasingly difficult for trauma researchers to compare and contrast the various approaches to trauma treatment given the problem of comparing differing terminologies and definitions. The concept of resourcing as a component of trauma therapy faces the same difficulties with a multiplicity of definitions and descriptions that are specific to a particular treatment modality.

Resources – Definition and Development

An examination of the relevant literature regarding therapeutic approaches to trauma, reveals a similarly discordant assessment of the definition of resources and their development. A client's resources may take many different forms and are defined, described and categorized in numerous ways. An overview of these descriptions and their practical applications in the therapeutic process provides an important insight into the current status of resourcing in child trauma therapy.

As trauma therapy begins, Phase I requires an assessment of a child's present capacities and available resources (Janet, 1924) in order to determine if there are lost resources to be reinstated, new resources to be learned and finally which existing resources need to be strengthened (Ogden et al., 2007). During the course of trauma therapy, the choice of resource, and the timing of its use, can be crucial in preparation for the confronting of traumatic memories and the processing of traumatic material.

Fundamentally, these resources are described as internal or external (Cloitre et al., 2006; Feather & Ronan, 2006). Internal resources refer to an individual's skills, abilities, and attitudes, which are mobilized in response to challenging situations. Examples include, the ability to mobilize communication skills so as to mediate interpersonal

confrontations, the ability to inject humor in order to diffuse tension in a difficult situation, as well as the ability to identify more optimistic alternatives rather than becoming overwhelmed with negative thinking and therefore feeling quickly defeated during trying circumstances. External resources include therapists and social workers; significant others; community parks and recreation programs that encourage healthy activity, such as neighbourhood basketball courts; as well as social and supportive services such as drop-in parent and tot support groups for single parents.

Many researchers have approached the task of further categorizing and defining resources from the perspective of a particular therapeutic approach, such as a Sensorimotor Psychotherapy approach. For example, Ogden et al., 2007 recommended organizing resources according to three levels of information processing: sensorimotor, emotional, and cognitive.

Somatic resources, Ogden and her colleagues suggested, could be found at the sensorimotor level of information processing and “emerge from physical experience” (Ogden et al., 2007, p.207). Somatic resources included grounding (i.e., the sensate experience of a connection through the lower extremities to the ground); breathing, since focusing on breathing can have a settling quality for those who have a tendency to hold their breath when anxious; and finally movement, as the ability to flee or raise an arm in defense can reduce the sense of helplessness or powerlessness frequently described by trauma survivors.

Ogden et al., 2007 defined emotional resources as including the act of crying as opposed to the holding back of tears, as well as the finding of comfort by spending time

with a loved pet for example, or a supportive friend. Cognitive resources encompassed the search for a fresh perspective or insight that opened up alternate ways of understanding the traumatic situation.

An example of the clinical application of Ogden et al.'s conceptualization of resources may be seen when a trauma sufferer becomes blocked in his or her trauma processing due to underlying beliefs related to the traumatic circumstances. A belief such as "I am not strong enough to protect myself," accompanied by some form of physical collapse as trauma memories surface, can benefit from cognitive resourcing in order to gain understanding (e.g., "I can protect myself now"). Further, using Ogden et al.'s definitions, sensorimotor resourcing may then be used to reinstate an active physical defense (i.e., the client may learn self-defense techniques such as throws, kicks, or pushes) so that trauma processing can resume.

Ogden and colleagues (2007) also proposed the broad categories of survival, relational, interpersonal, and environmental resources. They defined survival resources as those found in most animal species, such as the defensive responses of flight, fight, freeze, and submit. Relational resources were defined as those abilities or skills that promoted a connection to others, both where the client reaches out for support or assistance, as well as where others have extended themselves to the client.

Interpersonal resources were conceptualized as those found within the client such as the traits, abilities, and attitudes that the traumatic event, or memory thereof, had elicited. Environmental resources were thought to include items, programs, and services that

clients could access to ameliorate the strain of their circumstances (e.g., a community shelter or temporary foster home).

While Ogden and her colleagues struggled with a series of increasingly broader and arguably less helpful definitions for the concept of a client's resources, EMDR-oriented researchers sought out definitions, which were efficacious to their own particular therapeutic discipline. From the EMDR approach, Korn and Leeds (2002) proposed three similarly broad types of resources, (a) mastery experiences and images, (b) relational resources, (c) metaphors and symbolic images. These authors suggested that resources are found in a client's memories of past success. Picturing a calming location, real or imagined, they suggested, could also become a resource.

Korn and Leeds (2002) also proposed that resources could derive from supportive relationships in the present moment, provided that they are characterized by safety, strength, control of self and situation, and a sense of connection to self and others. Relational resources included examples of role models and other supportive figures from the client's life that possessed or embodied a desired resource. Even pets, spiritual guides, or literary characters that represented the quality or skill the person believed would provide the strength and/or confidence they lack, could be considered to be a resource in this ideation. Finally, the authors suggested that some people might find images of artwork or symbols, which evoke a positive sense of well being, to be a particularly helpful resource. This last approach was thought to assist with the stabilization of complex trauma clients for whom relationships with frightened or frightening people were the source of their traumatic experiences.

Other therapeutic disciplines promote the inclusion of the concept of resourcing without explicitly defining the resources themselves. Cognitive Behavioral Therapy for PTSD typically uses the resourcing components of psychoeducation, skills-training for arousal (i.e., relaxation techniques) and skills-training for affect (i.e., emotional coping skills; Cohen, Berliner et al., 2000; Silverman et al., 2008; Stallard, 2006). Saxe, et al., (2007) added cognitive coping, stress management, muscle relaxation, and thought stopping to this list of CBT components.

Psychoeducation in CBT refers to the provision of information about common symptoms following a traumatic event and is given during the first treatment session (Cohen, et al., 2000). The implicit assumption is that the therapist is providing the resource of knowledge to the client. This educative session typically includes a description of the most common symptoms of the post trauma response and how these symptoms will be treated during the course of therapy. The goal of psychoeducation is to “legitimize the trauma reaction, to help the patient develop a formulation of their symptoms to establish a rationale for treatment” (Harvey, Bryant, & Tarrier, 2003, p. 502).

Skills-training in CBT for symptoms of arousal typically includes diaphragmatic breath training and progressive muscle relaxation skills-training (Amstadter, McCart, & Ruggiero, 2007). Such techniques provide clients with the resource of relaxation skills, which may help them to cope with distressing symptoms.

Skills-training for affect, as a resourcing strategy in CBT, involves identifying and labeling emotions as well as understanding the causes and consequences of emotional

experiences. Again, a new skill set provides the resource, which may serve as a foundation or prerequisite to the regulation of post trauma emotions (Suveg, Sood, Comer, & Kendall, 2009).

After the foundations for emotion regulation are in place, therapeutic efforts shift to exposing the client to emotion arousal. Scenarios which encourage the client to practice his or her new skill set, or resource, with the benefit of the opportunity to talk through any emotional reactions that occur, permit the exploration of alternate emotion-related coping strategies.

Deblinger and Heflin (1996) adapted cognitive coping from Beck's (1976) cognitive treatment for depression. The extended goal of cognitive coping is to teach emotional regulation skills while simultaneously altering negative cognitions (i.e., negative beliefs or automatic thoughts about one's self). This CBT resourcing component was developed to teach children about the relationship between "maladaptive automatic thoughts, negative emotional states, and dysfunctional behaviors" (Saxe et al., 2007, p. 363). The child is taught how to perform a self-assessment of the impact of thinking and emotion on his or her own behavior. Cognitive coping equips the child with strategies to manage the anxiety that typically arises during later phases of trauma treatment.

Cloitre et al., (2006) presented another perspective on resources in their approach to working with sexually abused children. Cloitre and colleagues concerned themselves with the limitation or loss of resources in the experience of trauma. They considered trauma in children as "an event that overwhelmed resources" (p.4). They further

distinguished between resource limitations and resource loss, recognizing that resources were not necessarily permanent acquisitions in a child's developmental process.

A child's stage of life was once thought to define the resource limitations that he or she experienced when confronting trauma. These limitations resulted in a circumstance in which the child rarely succeeded in warding off or neutralizing, sexual, or physical threats. In addition, once a trauma has occurred, it creates a cascade of subsequent resource losses that continue during its typically chronic course and have significant consequences long after the trauma itself has ended (Cloitre et al., 2006, p. 5).

Cloitre et al., (2006) identified resource losses as the loss of physical safety and physical integrity. Less obvious losses included those of the many psychological and social-developmental opportunities and advances that would have occurred if the child's developmental growth had continued unimpeded. Additional potential resource losses (both short and long term) were identified as, "(1) loss of healthy attachment, (2) loss of effective guidance in the development of emotional and social competencies, and (3) loss of support and connection in the larger social community" (Cloitre et al., 2006, p. 7). These potential losses need not be actualized at the time of the trauma, which underscores the importance of early support and intervention for child trauma sufferers as a preventative measure.

Resources (or their lack) become especially apparent in the presence of a threat to self or stability. They function to minimize distress and catalyze growth (Ogden et al., 2007). Resources form the foundation of coping and the linking of resources builds coping strategies. Multiple coping strategies make available a repertoire of skills, efficacy

beliefs, and relationships that are supportive of not only healthy development, but a sense of safety and stabilization as well.

The safety and stabilization goals of resourcing were further explained using a neurophysiological interpretation in Ogden et al.'s Modulation Model (Ogden et al., 2007; Siegel, 1999). Affirming the role of physiological arousal, resourcing, in the context of the Modulation Model, was defined as the process of stabilizing clients within their individual windows of tolerance. The basic premise of the model is that people have a range of arousal tolerance within which they can remain present to experience, but outside of which, alternative and potentially unhealthy reactions occur that are geared toward psychological survival.

It is within that range of tolerance (which differs from person to person) that there is a zone of optimal arousal. This zone is where the person is alert and fully oriented. Ideally, learning occurs in this zone, within which a person is best able to pay attention, learn, integrate information, and make meaningful connections from his or her experiences.

From a neuropsychological perspective, it is through the neocortex, an area of the brain that is considered to be the most highly evolved and which is responsible for rational thought, logic, and the making of meaning, that an individual functions best within his or her particular window of tolerance (Glasser, 2000; Ogden et al., 2007; Porges, 2003). The neocortex processes information as an individual engages the action systems of daily living: play, energy regulation, social engagement, attachment, care giving, and exploration (Porges, 2003).

Both hyperarousal and hypoarousal negatively influence the functioning of the neocortex and therefore interfere with the healthy integration of ongoing experience. Extremes of arousal are highly associated with the defensive action systems of survival: the attachment or separation cry, hypervigilance, flight, fight, fright (tonic immobility), faint (flaccid immobility), and submit (Christopher, 2004; LaFreniere, 2005; Ogden et al., 2007; Porges, 2011) any of which, when activated, further impede the normal functioning of the neocortex.

Trauma therapists trained to recognize the state fluctuations related to arousal cycles can use the Modulation Model as a framework for identifying opportunities for resourcing and to assess a client's readiness for traumatic memory processing (Phase Two of trauma therapy). Some, including Brewin (2005), Ogden et al. (2007), and van der Hart & Brown (1992), have argued that trauma processing cannot occur outside this window, where there is a risk of re-traumatization which includes both hyper and hypo arousal states.

Ogden et al. (2007) asserted that trauma reprocessing occurs at the edges of the window of tolerance, as this level of arousal is closest to the person's state at the time the trauma was experienced. Ogden and her associates referred to this as state-specific processing.

Bromberg (2006) suggested that the crux of therapy is to deal with difficult issues in an atmosphere that is "safe but not too safe" (p. 4) and that doing so expands the client's window of tolerance. Therefore, resourcing is also a means to achieve a state of arousal

that is optimal for trauma processing, since the modulation of arousal allows for the flexibility to be aroused, but not so aroused, that processing cannot occur.

The field of interpersonal neurobiology, which concerns itself with the social aspects of emotions, attachment, affect regulation, and, interpersonal social behavior, for example, builds upon the concepts presented with the Modulation Model. Importantly, for resourcing, human nervous systems have regulatory processes to balance the highs and lows of the arousal cycles (Schoore, 2010; Siegel, 1999). Porges (2011) asserts as part of his Polyvagal Theory that, neurobiologically, attachment relationships provide the counter balance to the fear generated by a threat to safety and security.

The work of Mikulincer et al. (1993, 2003) further related the regulation of emotion and arousal to attachment theory. They suggested that an individual's attachment style determines his or her trauma processing and recovery.

Attachment style is an internalized representation, loosely defined as secure or insecure, of a person's relationship over time to his or her caregivers (Ainsworth et al., 1978; Bowlby, 1988, 1982/1969; Cassidy, 2008). A secure style is thought to develop when caregivers are reliably present and supportive during times of stress and it correlates positively with adaptability, resilience, and successful trauma processing (Ainsworth et al., 1978; Mikulincer & Shaver, 2007). An insecure attachment style, subdivided into ambivalent and avoidant categories, results when a negative conceptualization of relationships is formed (Ainsworth et al., 1978).

Additional relationships are formed throughout the lifespan with significant others who serve as objects or figures of attachment. Due to age differences, children's caregiver attachment issues may be more poignant than those of adults who have had

additional, and theoretically more varied, life experiences and relationships in the intervening years between their childhood caregiver attachments and the present day.

The theory of arousal modulation suggested that individual windows of arousal tolerance impact trauma recovery. Mikulincer et al. (2001, 2006) proposed the concept of attachment priming as a potential resource capable of modifying arousal levels to within parameters optimal for trauma processing. In attachment priming, the client is encouraged by the therapist to think of significant others who have previously demonstrated that they are comforting resources for support and security in times of stress. Focusing a client's thoughts on these significant others, or attachment figures, temporarily results in a reduction in the client's level of emotional arousal. This reduction may encourage trauma recovery by attenuating the level of arousal sufficiently such that therapy may proceed within the client's window of tolerance.

Mikulincer et al. (2006) demonstrated that attachment priming temporarily alters a person's attachment style to one that is more secure and is therefore a resource that may be further developed to encourage adaptive trauma recovery. Further, sensitivity to attachment style may direct the clinician to more relevant relational resourcing efforts. Research into attachment priming aimed at demonstrating and delineating its long-term efficacy is ongoing (Gillath et al., 2008), however attachment priming does add an interesting dimension to the variety of approaches that currently comprise the depth, breadth, nature and origin of trauma resource development.

The lack of a common acceptable definition of resources, and therefore what constitutes resourcing, across therapeutic disciplines and their theoretical underpinnings, is problematic for researchers who may find themselves inadvertently comparing the

proverbial apples to oranges. Since the definition of resources is usually linked to a particular therapeutic approach, it is prudent for trauma researchers to either choose a therapeutic approach in order to adopt its definitions, or explicitly derive and state their own novel criteria.

Resourcing Descriptions in Clinical and Research Literature

While, definitions of resourcing are difficult to discern in both clinical and research literature, descriptions of resourcing processes, activities, and constituents are found more often in the clinical literature. Clinical authors may be concerned with a clinician's ability to transfer the ideas of the author into actual practice and are therefore somewhat more thorough in their descriptions. Resourcing descriptions remain challenging to find in the research literature.

Very few research articles have made a reasonable attempt to explain or define the resourcing components therein, however, a study by Cohen et al. in 2000 was a noteworthy exception. In their study of CBT and trauma in children, Cohen et al. (2000) confirmed that both trauma-specific and trauma-related cognitions could lead to children's distress. Several other researchers have also found that higher levels of self-blame and shame can predict posttraumatic stress symptoms in traumatized children (Deblinger, Mannarino, Cohen, & Steer, 2006; Feiring, Taska, & Chen, 2002; van der Kolk & d'Andrea, 2010).

As part of Cohen et al.'s (2000) update on trauma-focused CBT for children and adolescents, they provided the background, description, and current empirical support for each of the four major resourcing components of this approach. This update included

detailed descriptions for the resourcing components of (a) cognitive coping, (b) thought stopping and thought replacement, (c) muscle relaxation and breathing techniques, (d) and finally stress management.

Cognitive coping. Cohen et al. (2000) described cognitive coping, as a resourcing technique that teaches children to recognize the relationships between negative automatic thoughts, negative emotions, and troublesome behaviors. Cognitive coping is a resourcing strategy that better equips children to challenge their own thinking, select other more positive thoughts, and to better regulate their emotional and behavioral states (Deblinger & Heflin, 1996).

For example, a child who was hit by a car while riding a bicycle may think that cycling is always dangerous, and as a result may be fearful of bicycles (i.e., a negative emotion) and refuse to ride any bicycles (i.e., an avoidant behavior). By substituting the original thought “riding a bike is always dangerous,” with a more functional thought, such as “I’ve ridden my bike many times and I was never hurt before, so bike riding isn’t always dangerous,” the child can feel more at ease and return to cycling with some confidence. With continued practice, where the child rides the bicycle while thinking positive thoughts and feeling confident, the positive thoughts and accompanying feelings and behavior are reinforced. This theoretically leads to the extinction of the negative thoughts and emotions.

Cohen et al. (2000) argued that cognitive coping has been part of trauma-focused CBT for sexually abused children in many studies and that that in itself offers some evidence of support for its effectiveness. This may be an example of circular reasoning, however,

they did concede in their argument for additional research, that claims cannot be made as to the magnitude of the contribution since cognitive coping has not yet been studied independently nor has it been studied in its role within the overall treatment approach.

Thought stopping and thought replacement. Thought stopping and thought replacement are also resourcing strategies intended to strengthen the child's sense of control over negative thoughts and emotions (Cohen et al., 2002). These strategies are often encouraged for children to allow them to manage disturbing thoughts that may occur outside of treatment.

Cohen et al. (2002) described teaching a child to interrupt negative thoughts by snapping a rubber band that was around the child's wrist. This physical sensation was accompanied by a verbal interruption such as "Snap out it" (p.1211). Thought replacement is taught by "instructing the child to think about a positive experience or memory and to mentally describe details of that experience" (p.1211). The child was prompted to recall experiences such as an enjoyable family vacation or a birthday party. The child was then encouraged to practice the two techniques until a sense of control over his or her own thoughts and emotions developed. As this power over thinking and feeling strengthens, presumably, so does a child's ability to tolerate stressful thoughts and emotions, which results in fewer avoidance behaviors.

Cohen et al. (2000) were unable to provide any empirical evidence to specifically support thought stopping, thought replacement, and their respective efficacies, and once again they argue for more research.

Muscle relaxation and breathing techniques. Cohen et al. (2000) reported that at the time of their writing, only two muscle-relaxation and breathing techniques were represented in studies of trauma-focused CBT for children. The first, progressive relaxation, is a relaxation technique where the practitioner alternates the tensing and releasing of muscles accompanied by controlled breathing. The second technique, abdominal breathing, is a focused deep breathing technique wherein the stomach, as opposed to the chest, rises with each inhalation and falls during exhalation.

In a related study, Catani et al. (2009) focused on a sample of children (n=31) traumatized by war and tsunami. They found no difference in treatment outcomes in a comparison between narrative exposure therapy and meditation-relaxation techniques although both treatments were effective. Of importance however, is that the children involved in this sample were Tamil children who lived in a Hindu culture, which embraces many meditation-relaxation techniques such as focused breathing and mantra chanting.

Although some research has been done with meditation in adult populations with substance abuse disorders concurrent to PTSD diagnoses, (Simpson et al., 2007) it remains unclear whether the Catani et al. (2009) research outcome would transfer to a western society where the relaxation techniques involved were less commonplace. Here again, more research into the components of resource development is needed.

Stress management. Cohen et al. (2000) referred to a stress management technique by an acronym that was never explicitly defined. They referred to self-regulation

techniques, “such as SIT,” as having been found to be efficacious in adult trauma situations.

Although the definition of SIT is unclear in their article, the acronym likely refers to “stress inoculation training”, a technique that promotes stress management by elucidating the nature of the stress response, enhancing a client’s repertoire of coping skills, and consolidating those skills through active real and imagined practice scenarios (Foa, Rothbaum, Riggs, Murdock, & Tamera, 1991). According to Foa et al. (1991) SIT appears to be successful in cases of adult PTSD, however, its utility with children has yet to be investigated.

Just as Cohen et al. (2000) referred to SIT with the apparent assumption that readers would immediately understand the acronym, numerous other studies mention resourcing efforts, but fail to describe them in any detail. Another example of the difficulties facing therapists and researchers when they examine the literature on resourcing is the 2006 CBT study by Feather and Ronan. Feather & Ronan (2006) attempted some detail in their pilot study of a manualized, trauma-focused CBT program for multiply abused children with PTSD, but they also mentioned concepts and acronyms that were never adequately explicated.

For example, when they made mention of the term psychoeducation, they defined it only in so far as to make the oblique statement “psychoeducation is about abuse and personal safety” (Feather & Ronan, 2006, p.134). They further made reference to “psychosocial strengthening and coping skills training” (p. 132) and only later briefly described psychosocial strengthening as “rapport building and orientation to therapy,

relationships, and support networks” (p. 136). For researchers or therapists attempting to make use of, or replicate their efforts, these vague definitions are a major impediment since much is open to interpretation.

Feather and Ronan (2006) introduced coping skills through “the 4-step coping template, the STAR Plan” (p.136). Coping skills training was described in terms of learning to recognize feelings and body reactions to trauma and anxiety, and to use relaxation techniques along with thought control strategies to manage symptoms. It is unfortunate that while Feather and Ronan (2006) provided more detail than many other available studies, it was difficult to determine from the article or its reference list what this “4-step coping template, the STAR Plan” actually was. A search using Google Scholar, of the terms contained in this quote, failed to yield a result other than this study.

Other reports simply provide a list of resourcing components, such as psychoeducation, mindfulness training, arousal modulation, relaxation skills training, and affect or emotional regulation strategies (Saxe et al., 2005; Suveg, Kendall, Comer, & Robin, 2006) without any attempts at defining, explaining or elaborating on the concepts. Unfortunately, the reader is left to apply context and details. The lack of specifics about resourcing efforts impedes generalization from these few studies.

Typical of trauma resourcing literature are statements such as “a relaxation technique was used to assist the patient getting relaxed. The patient is asked to tell the most enjoyed memory. This is considered as ‘safe place’,” (Ahmad & Sundelin-Wahlsten, 2008, p. 129) or “following a period of stabilization...” or “participants attended mindfulness training...” These statements leave it unclear as to how this supposed

stabilization was achieved, what constituted this stabilization, or what skills training program was actually implemented. Some studies only mentioned that they broadly applied an approach such as CBT, leaving it to the reader to determine what interventions were actually used.

Confusion in the Practical Application of Resourcing Across Disciplines

While Janet's (1924, 1930) tri-phasic approach and fundamental conceptualization of resourcing underlies current practice in the field of trauma therapy, the diversity of discipline-specific language makes the comparison of the practical applications of resourcing between treatment modalities difficult. It is worth examining how certain modalities handle these applications.

Modalities may be loosely assigned to a method of resourcing, which may be described as either predominantly prescriptive or predominantly client-centered. CBT treatment usually adopts a more prescriptive, manualized approach to resource development in trauma therapy, which focuses on psychoeducation and symptom management. Trauma-focused CBT programs are designed to target trauma issues and symptoms more so than other disorders (Feather & Ronan, 2006). Other models of trauma treatment including EMDR and the Developmental Needs Meeting Strategy (DNMS) are more client-centered (Schmidt & Hernandez, 2007) and rely on protocols to elicit direct, immediately relevant client information. Sensorimotor Psychotherapy (Ogden et al., 2007), among others such as the expressive therapies, also embraces a more client-centered and individualized approach to resourcing.

From the perspective of Sensorimotor Psychotherapy, Ogden et al. (2007) explained the client-centered method of developing resources that

...begin[s] with the recognizing and acknowledging of existing resources, the clients' abilities and current competencies...as well as their 'survival resources' that enabled them to cope with past traumatic challenges. From this basic orientation of validation, existing resources are acknowledged and expanded, and those resources that are undeveloped or absent are taught (p. 207).

Applied to the common resourcing component of psychoeducation, the Sensorimotor Psychotherapy approach advocates an initial assessment of the client's current understandings, capacities, and strengths. If, for example the client was experiencing trauma related to a sexual abuse, the subsequent personalized resourcing interventions might build upon the client's present knowledge of personal safety practices. This approach would require a discussion between client and therapist in order to collaboratively determine gaps in knowledge or possible misunderstandings.

It is not clear from the literature, whether the same client attending trauma-focused CBT, who self-reports an understanding of personal safety practices, would thereafter be exempt from participating in the psychoeducation portion of the therapy or if, despite the prescriptive nature of this treatment modality, it would be adjusted to respond to this situation. Neither does the EMDR approach give a clear indication of when to use the resourcing component of psychoeducation but rather vaguely suggests that it is to be used when a client's presentation suggests a need (British Columbia School of Professional Psychology; BCSPP, 2008).

This lack of clarity leaves therapists to rely on clinical judgment more often than not to make decisions about the individual application of resourcing components. Such situations may illustrate the notion that psychotherapy is as much an art as it is a science.

Psychoeducation is a common resourcing component in the majority of therapeutic approaches, yet it is practically applied in a different way by each model (i.e., in one model as part of a formal program of education; in others on an “as necessary, depending on where the client is at” basis; in still others, it is not mentioned but is nevertheless considered a part of basic therapeutic practice; Briere & Scott, 2006; Cohen, et al., 2000).

The confusion regarding the practical application of resourcing both across and within treatment modalities, contributes to the development of contentious positions in clinicians who find themselves without consistent guidelines for their practices (Silverman & Hinshaw, 2008; Silverman & Ollendick, 1999; Weisz & Weersing, 1999). Furthermore, discordant and poorly defined applications of resourcing may additionally contribute to the polarization of clinicians as they align themselves with approaches or models taught as professional development rather than within a critically reflective graduate program of study (Silverman et al., 2008; Stallard, 2006).

A clinician then tends to become an EMDR therapist or a Trauma Focused-CBT therapist, with a loyalty to the brand of therapy, as opposed to labeling him or herself as a trauma therapist who seeks the most efficient way to help his or her clients. While an exclusive loyalty to a particular treatment discipline may still lead to proficient therapists specialized in particular approaches, it might also obscure the critical evaluation of any favoured approach (Silverman & Ollendick, 1999).

The Comparative Efficacies of Resourcing and Trauma Treatments

It is helpful to not only examine the internal validity of the treatment components for the particular research population, but also to compare the various treatment modalities when analyzing any treatment efficacy. Significant debate has arisen in recent literature around customizing treatment approaches to specific populations.

Cohen et al. (2000), in their review of the empirical research on trauma-focused CBT for children, observed that research had difficulty accounting for the possible effects of gradual exposure (i.e., where the traumatized children are exposed to fear-inducing situations or thoughts in a graded manner) simply as a result of the therapy itself. Because the existent research had not separated the effects of one resourcing component (e.g., cognitive restructuring) from another (e.g., stress management interventions), particular efficacies could not be determined.

Stallard (2006) concurred in his meta-review of randomized, controlled trials for the treatment of children and adolescents with PTSD. He concluded:

The considerable variation within programmes in the use of specific treatment components and the way in which they have been adapted highlights the considerable heterogeneity within interventions that are generically termed trauma focused CBT. There is a need for deconstruction studies that allow for the relative value of the individual components used in trauma focused CBT to be determined (p. 905)

Recently, Ehlers et al. (2010) addressed the question “Do all psychological treatments really work the same for posttraumatic stress disorder?” These authors reviewed biases

in a meta-analysis by Benish, Imel, and Wampold (2008) which concluded that all bona fide treatments are equally effective in the alleviation of PTSD. The notion that all legitimate treatments for PTSD are equally effective contradicted the significant increases in effect sizes, seen over the past few decades, for those treatments that included traumatic memory (i.e., TF-CBT and EMDR; Ehlers et al., 2010).

Ehlers and colleagues (2010) concluded that a considerable body of research has indicated that there are significant differences in efficacies across treatment modalities, but within the most successful modalities, the treatments are relatively equal. As a result of their findings they recommended “further research into the active mechanisms of therapeutic change, including treatment elements commonly considered to be non-specific” (p. 269).

To wit, Harvey and Taylor’s (2010) meta-analysis of the effects of psychotherapy with sexually abused children found that measures of coping/functioning and social skills/competence contributed small effects ($g=0.44$ and $g=0.39$ respectively using Cohen [1988]; to the larger global gains $g= 1.37$ and $g=1.12$ for PTSD outcomes). Effect sizes are standardized mean gain scores (i.e., the mean change in outcome between pre-treatment and post-treatment; Lipsky & Wilson, 2001). That even as much as a small effect could be attributed to these two domains warrants further investigation.

Furthermore, Cohen et al. (2000), referring to trauma-focused CBT for children and adolescents, stated “there is a need to determine whether specific symptoms, types of traumatic exposure, and patients with specific demographics (i.e., gender, ethnicity, age of patient) respond better to a specific CBT component or combination of components”

(p.1218). It would seem that such an idea would best serve children if it were expanded to include any phasic approach to trauma treatment. Deconstruction studies, investigating the independent and cumulative contribution of components or the relative value of any given phase or component *across phasic trauma treatment approaches*, may lead to increased efficiency and improve therapeutic effectiveness. Such studies appear to be yet another future direction for clinical research.

Problems with the Diagnosis of PTSD in Children

Problems with terminology, definitions, and their application are common, not only for the comparing of different treatment modalities and resourcing as a component thereof, but at every stage of care for traumatic stress. Therapy in the field of trauma is shadowed by the criteria for PTSD as specified by the *DSM-IV-TR*. However, the criteria are restrictive, and many therapists deal with people traumatized by chronic, cumulative, and often more subtle events than those that are the focus of the *DSM-IV-TR*. The *DSM-IV-TR*'s purpose is to delineate a specific psychiatric disorder, however, it fails to deal with the far more common disturbances in growth and development that are a prevalent result of trauma in the general population.

Since a great deal of research in the field of clinical traumatology relates to a diagnosis of DSM-related PTSD, practicing therapists have extrapolated techniques and therapeutic models from those studies. This means that in practice, the distinctions between traumatic experience in any form, and a PTSD diagnosis, are blurred. Clinicians are burdened with the task of providing their clients with appropriate therapy, despite the

possibility that the rationale and funding for such therapy is largely dictated by a DSM-defined criteria that may actually be a poor fit for many clients.

Furthermore, none of the many studies on child abuse and neglect conducted since the 1970s have been incorporated into the present diagnostic system, which “continues to rely on the diagnosis of PTSD, which was originally formulated in 1978 to capture the psychopathology of Vietnam veterans, and has not changed substantially since then” (van der Kolk & d’Andrea, 2010, p.57-58).

Van der Kolk and d’Andrea (2010) contended that many of the diagnostic criteria for children in the *DSM-IV-TR* have some association with childhood adverse or traumatic experience, but children with trauma-related symptoms and behaviors are instead commonly diagnosed under classifications such as Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Bi-Polar Disorder, and Reactive Attachment Disorder.

For example, in the case of Attention Deficit/Hyperactivity Disorder the diagnostic criterion of inattention describes nine symptoms. Six or more of these symptoms must be present for at least six months and must be disruptive and inappropriate for the individual’s developmental level. These symptoms include (a) makes careless mistakes in schoolwork, work, or other activities; (b) often has trouble maintaining attention on tasks or play activities; (c) often does not seem to listen when spoken to directly; (d) often does not follow instructions and fails to finish schoolwork or chores (which is not due to oppositional behavior or failure to understand instructions); (e) often avoids,

dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework; van der Kolk & d' Andrea, 2010).

Any of these symptoms could be present for a child who is dissociative, or who is attempting to avoid either contact with others or stressful situations reminiscent of abusive relationships. Since children with histories of abuse and neglect frequently intersect with the medical and mental health care systems but remain diagnostically without a home, research on these populations is made that much more difficult.

Researchers and therapists must therefore use strategies and therapeutic techniques that have been investigated and proposed as treatments for PTSD, on children who may demonstrate some, but by no means all, features of PTSD. In the absence of a developmentally sensitive and trauma-specific diagnosis, children affected in more complex and subtle ways are instead diagnosed with an average of three to eight co-morbid axis I and II disorders (Pynoos et al., 2009).

Finally, often the criterion for effectiveness is the loss of sufficient criteria to maintain the diagnosis. Regrettably, this does not always mean that the child is free from unwanted thoughts, feelings, and behaviors. Instead, many children who no longer meet PTSD diagnostic criteria still experience trauma reactions and do not differ significantly from those children who meet the full diagnostic standard (Cohen et al., 2000; Stallard, 2006). Stallard (2006) adds that a lack of follow up data makes it difficult to assess whether post-treatment gains are maintained.

Child-Specific Research on Psychotherapeutic Approaches

The body of child-specific research on psychotherapeutic approaches to working with traumatized children is beginning to grow; however, research on children and resourcing is scant. An exhaustive search using PsycINFO, Web of Knowledge, and Academic Search Complete failed to identify studies, which specifically investigated resourcing with children. Several authors identified this scarcity of empirical or clinical data as a detriment to informed practice (Fairbank et al., 2007; Friedman et al., 2007; Silberg, 2000; van der Kolk, 2005).

Furthermore, little research or even theoretical information can be found on the *process* of therapy for children (Green, 2009). It is important to differentiate between client expectations related to the process of therapy (i.e., what happens as part of therapy in terms of an assessment, whether payment is part of the process, or whether therapy is covered by a third party payer, obligations of cancellation, informed consent, and the like) and expectations related to the outcomes of therapy (i.e., whether the therapist and the therapeutic approach are likely to help with the presenting issues of the client). While adults attending individualized trauma therapy may be somewhat familiar with its conventions, the same cannot necessarily be said for a child in a similar position. Nor can it be assumed that child-clients would have a pre-conceived idea regarding informed and likely outcomes.

The therapeutic process for adult trauma sufferers tends to follow a conventional pattern. Adults may be the initiators of treatment by finding themselves a therapist, or they may find their way to therapy by referral, or via the suggestion of an allied health

worker, such as a family physician or social worker. Thereafter, varying degrees of understanding and expectations are brought to the first meeting between client and therapist. At this time, it is incumbent upon the therapist to ensure that the potential client has an understanding of what to expect from the therapeutic process.

Although adults can research and understand the adult experience of the therapeutic process prior to their participation in therapy, an exhaustive search of the literature failed to locate a trauma treatment-related study that included children's experiences of the trauma treatment *process*. The lack of child-specific research in the area makes it difficult to determine the extent of how a child's experience of the therapeutic process differs from the adult experience and what impact this may have on therapeutic delivery and ultimately, success (Stith, Rosen, McCollum, Coleman & Herman, 1996; Strickland-Clark, Campbell, & Dallos, 2000).

Consistent with the larger picture of psychotherapy, the vast majority of trauma therapy techniques and approaches have been distillations and extrapolations of adult-oriented methods, adjusted by individual clinicians to assist children who struggle to cope and adapt in healthy ways (Ahmad, Larsson, & Sundelin-Wahlsten, 2007; Silverman et al., 2008; Shirk, 1999). Typically, language and medium (e.g., art replacing talk) are altered based on age-related stereotypes rather than an assessment of a child's developmental level (Jaberghaderi et al., 2004; Shirk, 1999).

Children do not participate in the therapeutic process in the same way as adults do (Pearce & Pezzot-Pearce, 2007; Pretti-Frontczak & Bricker, 2004; Shirk, 1999).

Frequently, a child is brought to therapy because the parents are unable, or unwilling, to

tolerate the child's symptoms. The caregivers may have exhausted their own coping capacities, and are unable to alleviate their child's suffering. In response, many therapeutic approaches are often geared to resolving the parents' frustration and distress by stopping the child's unwanted behaviour or upsetting symptoms (Shirk, 1999, Green, 2009). This arrangement may not focus on what is distressing or important to the child for optimal recovery.

Since children are more typically *brought* to therapy, or *sent* for counselling (Green, 2009) and are not the originators of their therapeutic experience, their immediate concerns (e.g., children might wish to feel safe, or may cry for parents to make "the bad man go away") are often not given prompt attention, nor are their resources inventoried or acknowledged. It is their symptoms and behaviors, not their experience of the world that is the focus of exploration.

Since taking part in therapy is not a child's informed decision based on an understanding of what therapy entails, but rather a decision made by others, the therapist/client relationship may be compromised by this circumstance. The therapist may become yet another adult in the child's world, akin to a teacher or a coach. The therapeutic focus may therefore become fixed on what the child is doing wrong, or what upsets his or her parents.

Some therapies with children are essentially minimally modified versions of an adult therapy and may indicate a failure to consider the conceptual demands placed on the child during the experience (Shirk, 1999). This includes the child's understanding of such concepts as help, feeling understood, trust, boundaries, and relationship dynamics.

Simplifying language, or replacing the act of “talking things through” with art or play, does not sufficiently convey the nature or expectations of what therapy means, what will happen in therapy, what is needed from the child, or what is to be expected from the relationship between the child and the therapist. For children, therapeutic processes are most often enmeshed or bound by developmental processes. The act of helping can only be met by the child at his or her developmental level. For example if the child is at a place of trust vs. mistrust (i.e., the first stage of Erikson's theory of psychosocial development) and the therapist is working on identity vs. role confusion (i.e., the fifth stage of Erikson's theory of psychosocial development) there is a mismatch that interferes with the therapeutic process (Erikson, 1956, 1963). It is incumbent upon the therapist to be sensitive to this.

In his chapter, *Developmental Therapy*, Shirk (1999) asserts that development moderates the effectiveness of many child therapeutic treatments. He explained that children vary widely in their social, cognitive, and emotional capacities, many of which may be related to developmental level rather than simply to age. The fact that children exhibit similar problems does not necessarily mean that the children themselves, or each of their individual needs, are the same. Hence, it is unrealistic to expect uniform treatments to yield uniform results.

Shirk (1999) identified the following four basic developmental principles for evaluating the developmental sensitivity of clinical child therapy. These principles were similarly proposed for the assessment of the developmental appropriateness of various resourcing approaches:

1. Development involves a series of reorganizations in the child's cognitive, social, and emotional capacities. These capacities vary significantly for children at different levels of development.

2. Development is characterized by the principle of *equifinality* (i.e., the belief that multiple pathways or processes can yield similar outcomes). According to Shirk (1999) and Hill (2005), this is in contrast to a long-standing and dominant belief in the field of child development that held that there was only one right pathway or process that had to have been followed to result in a particular developmental or behavioural outcome.

3. Development requires adaptation to stage related or age related challenges. Shirk (1999) pointed out that adaptation in the face of challenge pits evolving capacities against life's changing demands. Adaptation cannot be reduced to a single set of skills, behaviours, beliefs, or relationships. Challenges can be unexpected, frequent, and jarring. Competencies mediate between challenges and adaptation.

4. Development is embedded in a social context. Every intervention being considered must be evaluated with regard to the child in his or her social context. Shirk (1999) wrote "maladaptation is a function not only of the ratio of individual vulnerabilities and competencies, but of the balance between environmental potentiating and protective factors" (p. 62).

Shirk's (1999) notion of competencies mediating between challenges and adaptation is an excellent way to regard the role of resourcing as an intervention directed at improving such competencies, relevant to a child's developmental stage, during the course of a therapeutic intervention. Green (2009) and Shirk (1999) proposed that it would be

helpful if a child's existing and emerging developmental competencies were acknowledged, and the child actively engaged with respect to these competencies, in the therapeutic process. Shirk (1999) suggested that the efficacy of treatment may have as much to do with matching the treatment to the emerging developmental competencies as with any other factors.

Several authors have also addressed the developmental aspects of children in therapy, but only in so far as these aspects related to each of the author's particular therapeutic approaches (Gil, 2006; Lieberman & Van Horn, 2004; Pretti-Frontczak & Bricker, 2004; Rivard et al., 2003; Sadock & Sadock, 2005). These studies tended to speak to *what* the therapist was doing with the child, rather than *how* the process worked, or what aspects or components of the therapy helped to ameliorate symptoms.

Pearce and Pezzot-Pearce (2007) advanced the position that in addition to traditional diagnostics, assessment from a developmental perspective would include descriptions of the "pathogenic processes" or mechanisms that contribute to and maintain problematic behaviours in the children undergoing therapy. When the focus is placed on the problem and diagnosis, the role of non-diagnostic information, such as the child's existing resources, developmental level, and contextual factors are overlooked (Kazdin, Bass, Ayers, & Rodgers, 1990).

Many authors prescribed a course of action aligned with a particular approach to therapy, as opposed to suggesting the flexibility offered by applying different therapeutic principles tailored to individual cases (British Columbia School of Professional Psychology; BCSPP, 2008; Abueg & Fairbank, 1992; Feather & Ronan, 2006). This

tendency can be found in the manuals of treatment protocols for each specific set of symptoms or conditions (e.g., EMDR has at least three manuals of specific EMDR protocols for such things as panic disorders, phobias, illness and somatic disorders, and many aspects of PTSD; Leeds, 2009; Luber, 2010a; Luber, 2010b).

The prescriptive approach (for instance that of CBT), wherein a resourcing program of psychoeducation and skills training is administered to all who seek help, can risk missing or even dismissing the child's individual resources. In the past, efforts at prescriptive resourcing, including psychoeducational and skills training prevention programs, may have unintentionally harmed children at risk (Pan & Bai, 2009; Shirk, 1999). These programs sometimes failed to consider social and contextual factors, such as the effect of peer pressure. This was the case in the international Drug Abuse Resistance Education program (D.A.R.E.) which resulted in iatrogenic effects which were most likely the consequence of the exposure to and negative influence of a high-risk peer group (Dishion, McCord, & Poulin, 1999).

In addition, there is a risk of re-traumatization when a child's individual resources, developmental level and contextual situation is not thoroughly considered and understood. This may occur due to the mismatch of the intervention to the client's current state of arousal, or due to the mis-attunement of the therapist to the client's present experience (e.g., such as with the dissociated client; Bromberg, 2011; Ogden, et al., 2007; Scaer, 2001; Silberg, 2000). This may lead to negative treatment outcomes and possibly to a re-enactment of the child's traumatic experience.

The generalization of research results for children also raises concerns. For example, Stallard (2006) wrote that “comparatively little is known about the efficacy of CBT for young children with only two randomized controlled trials involving children under the age of 7” (p. 901). He further explained that in terms of CBT and PTSD few studies have demonstrated treatment efficacy with children less than 10 years of age.

Expanding our knowledge to include what children can tell us about their resourcing experiences may help us glean insights that may lead to improved treatment efficacy, and increased efficiency. A primary consideration of the child’s perspective could result in an additional benefit; the improved recognition of the therapist’s unseen biases and errors.

Child-Client Participation in Qualitative Research

Delving into the experiences of children is no longer a rare occurrence in most areas of research. The number of book and journal publications on the subject has grown, most notably since the 1989 United Nations Convention on the Rights of the Child (Public Health Agency of Canada, 2009). This convention introduced the importance of enabling children to express their opinions on important matters and decisions that affect them (Hill, 2005).

Several authors reported that, until the mid-1990s, research was predominantly positivist with measurements focused on child variables as opposed to the children themselves (Clark & Moss, 2001; Graue & Walsh, 1998; Green & Hill, 2005; Greig & Taylor, 1999; Hill, 2005). Hill (2005) noted a lack of qualitative inquiry incorporating children’s experiences and attributed it to a dominant developmental paradigm, which

portrayed children as deficient, incapable, and unreliable human beings. The present view of children is that they are competent to provide insight into their own experiences.

Despite an absence of research into the experiences of children and adolescents in trauma therapy, two qualitative studies have focused on children's experiences of family therapy. These studies determined that children do have different interests and concerns in the therapeutic setting than those expressed by adults (Strickland-Clark et al., 2000; Stith et al., 1996.)

The qualitative inquiry conducted by Strickland-Clark, Campbell, and Dallos (2000) into children's and adolescent's views on family therapy used semi-structured interviews and grounded theory. Strickland-Clark and colleagues concluded that young people were concerned about a number of issues including the importance of being listened to, that therapy might elicit painful memories, concerns regarding the reactions of family members, as well as struggles with the expression of thoughts and feelings. Clearly children and adolescents are capable of reporting on their own experiences and such reports would offer additional insight into the therapeutic process.

An earlier study focusing on pre-adolescent children's experiences in family therapy, found that children participated in family sessions differently than adults in that they preferred the use of activity and play over talking (Stith et al., 1996). With few exceptions (notably Edmond, Sloan, & McCarty, 2004), treatment efficacy studies privileged the clinician's knowledge and judgment and applied standardized treatments that often failed to include the perspective of the person who experienced the trauma

(Cassidy & Mohr, 2001; Duncan, Sparks, & Miller, 2006; Edmond et al., 2004; Miller, Duncan, Sorrell, & Brown, 2005; Rivard et al., 2003; Wampold & Brown, 2005).

The protean nature of trauma, development, and resourcing presents significant challenges to future research on resourcing for children who have been traumatized. The literature on child therapy in general is skewed heavily toward quantitative research. One reason the literature is scant with respect to how children navigate the process of therapy, and therefore of resourcing, may be a lack of qualitative inquiry.

The employment of qualitative methods may provide a more balanced approach to the research literature by acknowledging the child's perspective and agency within the therapeutic process. A study focusing on qualitatively understanding the experience of the resourcing component of trauma therapy from the child client's perspective may begin to fill the many gaps, disparities and divisions in the body of knowledge on resourcing.

This would further inform not only the definition of resourcing, but also the practice of resourcing across treatment modalities. Information gleaned from a phenomenological, qualitative inquiry into children's experiences of resourcing may ideally serve to improve the current repertoire of treatment options for children exposed to trauma.

Chapter Three: Research Process

Rationale for Phenomenological Methodology

To better understand the lives and development of children may require multiple methodological approaches. In the case of resourcing, or resource development, which has no established body of research for child populations, it is likely that questions requiring answers from both quantitative and qualitative vantage points would best inform our knowledge and interventions. At this nascent phase of research in this area, it seems reasonable to begin by consulting those very children who, it is hoped, resourcing benefits.

The work of Somekh and Lewin (2005) on research methods in the social sciences was influential in informing my decision regarding which methodology best related to the topic and questions being posed. They related that

... differing understandings of the nature of knowledge and truth (epistemology), values (axiology) and being (ontology) are the key determinants of methodology, providing the overarching framework within which appropriate theoretical frameworks and research methods are selected as the first step in research design. (p. xiv)

All of these understandings fall under the rubric of phenomenology. “Phenomenology addresses how human ‘consciousness’ forms what we understand of the world. It is *the study of* (‘ology’) *what appears to us* (‘phenomena,’ as opposed to *noumena* – things in themselves)” (Fischer, 1998, p. 114).

This is not to say that ‘what appears to us’ or what we experience is necessarily the source or foundation of knowledge and insight, rather, that experience is a subject addressed by phenomenology. Experience and its structures constitute an object of phenomenological investigation.

Phenomenology, through the examination of experience, helps to define the phenomena upon which claims of human knowledge rest. This includes knowledge about the nature of consciousness, a distinctive kind of first-person knowledge gleaned through a form of intuition (Audi, 1995; Giorgi, 1997). Hass (2008) referred to this as *knowledge by acquaintance*.

In the case of a child’s understanding of his or her resourcing experience, this *knowledge by acquaintance* is precisely what requires elucidation. The researcher is mindful that such elucidation is naturally limited by the constraints inherent in human discourse and mutual understanding.

Merleau-Ponty’s (1962) conceptualizations of knowledge by acquaintance may be of particular relevance to understanding children’s experiences. Extending Husserl’s (1913) account of the lived-body, a person’s objective and subjective experience of his or her own body, Merleau-Ponty (1962) asserted that people live “through” their bodies in the way they live through language. The body is therefore able to communicate with its own intrinsic language.

Children are particularly focused on their sensory experiences and acquire much of their knowledge through bodily sensation and perception. Meaning is frequently expressed using an emerging language of the body, whereas adults may have learned to

disregard body-talk. A phrase such as “the time when my dad’s friend came over and I got all squidgy” may, upon further exploration, disclose that “squidgy” is an important part of a fear response. A sensitive ear might attend to “squidgy” and explore its meaning for that child, which could be communicating, for example “I am not safe when he’s around.” Youth might use descriptors such as “It just grosses me out and I feel almost sick to my stomach when he’s around.” Again, the body is doing the communicating.

Descriptive phenomenological investigations pay attention to, and respect, direct perception and experience and undertake to describe these phenomena without looking for external or reductive explanations (Andersen-Nathe, 2008; Giorgi, 1997; Kostenius & Ohrling, 2008; van Manen, 1990). Attention remains at the level of everyday awareness (the human order, referred to as the natural attitude), even while acknowledging that perception and experience are rooted in the physical and psychological orders. This acknowledgement considers that experience and perception are neither ahistorical nor unmediated (Stoller, 2009).

The phenomenological investigator asks simply “*What is this phenomenon?*” Later, the investigator can reflect on how different theoretical and research contributions address various aspects of the complete phenomenon (von Eckartsberg, 1998). Since children’s experience of resourcing has not been previously investigated, a phenomenological approach aimed at discovering the common constituents of this experience seems appropriate.

The choice of research question and phenomenological methodology reflect my belief that children are not only capable of providing valuable, reliable information which expresses their realities, but also that children hold the data and knowledge I seek. I hold a moral perspective, which considers and promotes the idea that children are persons of value and persons with rights. I respect each child as a unique and valued informant representing his or her own reality. Despite their individual differences, however, I believe that children also share common experience and meaning which, taken together, may inform and improve child trauma therapy.

Descriptive Phenomenological Psychological Method

Qualitative research, such as is the nature of phenomenological inquiry, offers the investigator a chance to explore the human experience in ways that quantitative study cannot. Issues of reliability, however, require an attention to a rigorous and internally consistent approach. Giorgi (2009) adapted the principles behind Husserl's (1913) philosophical phenomenological methodology to his own descriptive psychological approach, which offers a measure of internal consistency that demonstrates a commitment to establishing the scientific status of its findings.

Giorgi and Giorgi (2003) noted that in order to call psychological research Husserlian and phenomenological, a researcher must, employ the phenomenological psychological reduction. This reduction includes the bracketing of past personal and theoretical knowledge of a phenomenon so that "full attention can be given to the instance of the phenomenon that is *currently* appearing to the researcher's consciousness" (Giorgi and Giorgi, 2003, p.355). In other words, Giorgi and Giorgi (2003) encouraged

the researcher to separate the actuality of the current experience from any preconceived meaning, biases, or context.

This is not to suggest that the researcher attempts to forget past knowledge, but instead uses bracketing as a means of critical evaluation with an intentional focus on the present experience. The researcher remains mindful that present experience is usually evaluated based on past experience and therefore is vigilant in his or her efforts to remain open to what it is taking place in the current moment (Giorgi, 2009). Giorgi and Giorgi (2003) also insisted that the investigator simultaneously refrain from making ontological claims regarding the phenomenon.

After the process of bracketing Giorgi's approach requires that the researcher use a concept called imaginative variation "to discover the essential characteristics of the phenomenon being investigated" (2003, pp. 355-356). Imaginative variation reduces the phenomenon to its most basic form, while the process of eidetic generalization enriches and completes an understanding of the thing itself.

To better understand the role of imaginative variation, it is helpful to proceed from the writings of Husserl (1913). He maintained that people empirically encounter things all the time; that is how objects are given to us. For example, as the object is encountered, I, as an investigator, can direct my attention to any one of a number of characteristics inherent in the object. Further, I can attribute the object to any number of categories since the object is rich with detail. Yet, to understand an object merely by its qualities or characteristics, in isolation, is to the sacrifice of all that it is. To examine a table and to perceive of it as brown and made of wood with four legs and a flat surface does not fully encompass the more meaningful categories of "furniture" and "eating

place” that are a part of its “tableness.” This holds true for abstract phenomena as well (i.e., what Husserl would consider to be objects of the mind).

In the case of a study on children’s experiences of resourcing, imaginative variation is the process that selects which units of meaning are critical to the specific identification of the experience as particularly a *resourcing* experience. More broadly applicable constituents, as well as the fundamental structure of the experience, can then be derived from the individual reports. Each individual participant report need not express each constituent, as it is the collective data that speaks to the existence of the constituents that comprise the resourcing experience.

Giorgi (1997, 2006, 2009) adopted a descriptive rather than an interpretive tone in the search for these underlying psychological constituents or essences. A descriptive approach follows the ideas of Husserl more closely in that researchers aim to reveal an essential but general meaning structure in a phenomenon. Researchers accomplish this by attempting to describe only what is reported to them in all its richness and complexity. A descriptive approach requires that researchers restrict themselves to making assertions based directly on the participants’ own descriptions, without adding to, or subtracting anything from, the data.

The interpretive tone or approach to phenomenological psychological inquiry is a separate school of thought that conversely follows the body of work of Heidegger (1962, 1977), Gadamer (1976, 1986), and Ricoeur (1976, 1981) and adopts the position that researchers are embedded in the world of language and social relationships, as well as the inescapable historicity of all understanding. Heidegger (1977) suggested that researchers listening to a person’s report of his or her experience are themselves experiencing a thing

that has already been interpreted. Arguably, the distinction between the descriptive and interpretive approaches may be a matter of the degree of interpretation involved in the experiences and their reporting. However, the descriptive Husserlian methodology proposed by Giorgi and Giorgi (2003) attempts to avoid interpretation as much as possible in order to best represent the data, and the thing itself, as it was presented.

Another more concrete perspective on the descriptive vs. interpretive approaches in phenomenological, psychological methodology holds that the descriptive variation relies on direct verbal descriptions of the experience of the participant as evidence of the basic constituents of the phenomenon, whereas, the interpretive variation expands the obligation of evidence to include a broader range of expression, such as art, action, or text.

According to Gadamer (1989), interpretation can point to something or point to the meaning of something. Descriptive phenomenology only points to something. Giorgi and Giorgi (2003) described a constituent as the most invariant meaning for a given context, as such, it cannot be further reduced and instead reaches a moment where it either is or is not part of the phenomena. Resourcing, for instance, may occur in various contexts, not all of which have therapeutic intent.

Concerns regarding Giorgi's approach maintain that any attempt to delineate a phenomenon cannot be truly free from interpretation. "Experience is at once always already an interpretation and is in need of interpretation. What counts as experience is neither self-evident nor straightforward; it is always contested..." (Scott, 1991, p.797). The nature of experience is that it requires an active participation on the part of the

‘experiencer’ who is not merely a passive receptacle but who actively ascribes meaning and context.

The meaning of the experience for the participant can only be understood via the imperfect conduit of language in all of its forms. However, the phenomenological researcher also has an active role in how he or she chooses to view the description of the experience and can do so with a degree of focus and distance, with the intention of preserving as much of the participant’s ascribed and reported meaning as possible.

According to Giorgi (2006) the findings arrived at using a phenomenological methodology will be “intrinsically general” (p. 356). As such, constituents are “considered to be typical rather than universal” (Giorgi & Giorgi, 2003, p.250). The Giorgi and Giorgi (2003) descriptive phenomenological psychological methodology, therefore, is an appropriate approach to initially examine reported experiences from which phenomenological and psychological meaning and applications can be derived.

Giorgi and Giorgi (2003) did not pursue absoluteness or universality, but rather advocated a degree of generality for psychologically significant findings. Thus, the essential structure revealed in this study of the resourcing experiences of children undergoing individualized trauma therapy, is highly contextual and not universal, although, as will be evident in the discussion on implications, the findings have general principle applicability. Hence, I believe a descriptive phenomenological psychological methodology is consistent with my research question.

The Research Sample

The participants of this study were a purposefully selected group of 10 children, 13 to 17 years old, who were attending trauma therapy and who had completed at least one resourcing session as part of this therapy. These children had traumatic experiences (e.g., vehicle accidents, abuse, neglect, sudden loss of a parent) in their life histories and were in the care of trauma therapists.

Several sampling approaches were combined in order to locate participants. Convenience sampling (Hill, 2005), through a network of child therapists who practice in the southern Vancouver Island and Lower Mainland regions of British Columbia, was combined with snowball sampling, which allowed the children or parents, and therapists to act as informants to recommend similar individuals (Somekh & Lewin, 2005). These approaches to obtaining participants are consistent with non-probability research such as this proposed phenomenological study (Bloomberg & Volpe, 2008).

The criteria for selection of participants was threefold (a) all participants were engaged in trauma therapy with a licensed therapist; (b) during the course of the trauma therapy, and within one month prior to being interviewed for this study, the child attended at least one session devoted to, or that included, resource development; (c) the participant was of sufficient developmental ability to act as an informant (i.e., within the nine to seventeen years of age range). The actual range of participants' ages was between 13 and 17 years.

Resource development and resourcing were phrases that were used interchangeably in the recruitment process. Therapists identified that they had used resourcing with the

participants and more importantly, the participants themselves defined whether or not they had received this type of intervention based on the following paragraph, which appeared on the participant information sheet (see appendices G, H and I):

Hi. My name is Rochelle and I am working on a school project studying children's experiences of resourcing when working with their counsellor. Maybe recently you learned something about yourself, or discovered a skill you have or a person who is helpful to you that helped you get past something that was hard for you. Your counsellor might have called this a RESOURCE. A resource can be any skill or ability, or person or thing that helps you. It can be something inside you or it can be something from outside you. Do you think you could describe an experience of finding a resource?

Why this is important: I am interested in hearing about any experience you had while seeing your counsellor that might be a resourcing experience for you.

The criterion of at least one resourcing session was intended to ensure that the participants had sufficient experience to inform the research and to reduce the potential risk of distress from recollecting trauma-associated experiences. Since the research focus was the resourcing experience of the participants and not on the treatment modality and kind of resourcing, I was blind to this information. Participants were referred from five therapists.

As part of informed consent, I discussed with the participants the possibility that a question or interaction might relate to upsetting memories, or that issues the child was

working on with the therapist/counsellor might come up. I explained that if there was any discomfort, the child could choose to not talk any further. The criterion of the session(s) having to have occurred within the month prior to the interview meant that the resourcing experience was within reasonable limits of memory and recall for children. The criterion, relating to the child's developmental stage, recognized the variability in children's abilities to recall events, focus attention, and articulate responses.

Overview of the Research Design

The following list summarizes the steps taken to complete the research:

1. Prior to actual collection of data, a selected review of the literature was conducted to study existing theory and research in the areas of clinical psychology and trauma therapy, resourcing approaches, developmental psychology, phenomenology and phenomenological methodologies.
2. A research application was approved by the Human Research Ethics Board of the University of Victoria (Appendix C).
3. Recruitment of participants began through networking, and snowball communications via telephone, e-mail, or face-to-face encounters. Therapists received an information sheet (Appendix G) and participants and /or their caregivers received an information sheet (Appendix H, I) as well, which detailed the study, including time commitment, consent, and an explanation of confidentiality (Appendix J).
4. Audiotaped, semi-structured, in-depth interviews were conducted with all 10 selected participants. The first interviews typically lasted from 45 minutes to one hour

and only the first three participants were contacted with a follow-up question, which I had added to the interview questions for the remaining participants after these first three people had completed their interviews.

5. Interview data was transcribed, analyzed, and synthesized by the researcher.

6. Participants were sent a copy of their individual, transcribed interviews as well as the meaning extracted by the researcher, for confirmation of content and intent.

7. A final report was generated.

Data-collection Methods

Rich descriptions are best obtained through dialogue (Giorgi, 1997, 2003; Spinelli, 2005; van Manen, 1990). The interview is a well-established dialoguing technique used as a means of eliciting valuable and detailed descriptions (Barbour & Schostak, 2005; Berg, 2004; Gall, Borg, & Gall, 1996; Greene & Hill, 2005; van Manen, 1990). Several authors, for example Creswell (1998), Kvale (1996), Patton (2002), and Weiss (1994), have attested to the efficacy of interviewing as a technique able to capture a person's perspective on a particular event or experience. An in-depth, unstructured or semi-structured interview, or discussion is methodologically appropriate for descriptive phenomenological inquiry (Groenewald, 2004; Todres & Wheeler, 2001; Westcott & Littleton, 2005).

The interview in child-centered research is fundamental as a tool for qualitative inquiry (Greene & Hill, 2005). Other strategies, including vignettes (Barter & Reynolds, 2000; Greene & Hill, 2005), focus groups (Hennessy & Heary, 2005; Morgan, Gibbs,

Maxwell, & Britten, 2002), and draw-and-tell methods (Driessnack, 2006) also use questioning as the primary mode of gathering data. In their chapter on phenomenological approaches to research with children, Danaher and Briod (2005) simply stated that the most widely used method is unstructured or semi-structured interviews.

Despite concerns about children's supposed incompetence as interviewees, there is substantial support for the use of interviews as a primary tool with child participants (Greig & Taylor, 1999; Paton et al., 2009). Selection of this data collection method reflects my desire to achieve the closest possible approximation of the participants' experience.

Interviews have limitations as well as strengths. Their value may rest upon the skills of the interviewer. Participants are likely to vary in their abilities for reflection, description, or articulation (Greene & Hill, 2005; Kortessluoma, Hentinen, & Nikkonen, 2003; Wescott & Littleton, 2005). Interviewers draw the participant's attention to particular situations or aspects of the person's experience; hence, the outcomes of interviews are dependent upon, and a result of, the interaction between interviewer and participant (Bloomberg & Volpe, 2008).

Interview schedule of questions. A brief demographic questionnaire (Appendix D) and a set of semi-structured interview questions were constructed based on the research question. Follow up questions were open-ended and posed with the view to expanding on ideas presented by the participants. The interview format is included as Appendix F.

Interview process. I contacted prospective participants and their parents, described the purpose of the study, invited the children's participation, and requested a convenient

date and time for face-to-face interviews. Copies of all consent forms, interview questions, and survey questions were made available to the participants and their parents prior to any contact with the participants. Parental consent and participant consent was obtained for all interviews.

A brief demographic questionnaire was completed at our first meeting. The child was then asked to think of an alias to be used to protect her/his identity. Participants were also asked to select either a \$10 iTunes card or a movie pass certificate as an acknowledgment of their participation in the study.

As suggested by Kortessluoma et al., (2003), Nelson and Quintana (2005) and Wescott and Littleton (2005), I used questions of a general introductory nature at the beginning of the interview to establish rapport and ease into areas of deeper meaning. In keeping with Graue and Walsh (1998), Greene and Hill (2005) and Clark and Moss (2001) who suggested that interviews with children require negotiation and flexibility, I negotiated the interview process with each participant at the beginning of the interview and discussed with the children what it was that I was asking of them.

All interviews with child participants were conducted face-to-face, and audio-recorded in their entirety. Following each interview, audio recordings of the interview were transcribed verbatim. A follow up question was asked of the first three participants I interviewed as I had added this question to the interviews of subsequent participants. This follow up question “If, when you started your resourcing session(s), the upset or disturbance about the whole issue you worked on was rated at 10/10, what would you rate it now - two weeks, three weeks, four weeks or five weeks - after your session?” resulted

from what I had learned during the interview process. The participants and I decided that a meeting was not necessary and therefore the question was posed through email. The question and the written email reply were incorporated into the transcription of the interview for those three participants just as it had been included in the original transcripts for the remaining participants.

All participants were informed that, upon completion of the study, all audiotapes would be destroyed and that transcribed interview documents would be available for no more than five years from the completion of the project and would be destroyed at that time.

Data Analysis

Procedure overview. The research began with the collection of descriptions of the experience of resourcing, in the context of trauma therapy, from 10 youth-participants. Descriptions were obtained through semi-structured in-depth interviews. The purpose of the interviews was to have the participants describe, in as faithful and detailed a manner as possible, their experiences of resourcing as a part of their trauma therapy sessions.

Each interview was then transcribed verbatim, and interview transcriptions became the raw data of the research. In accordance with Giorgi and Giorgi (2003) the following steps were undertaken to complete the analysis:

1. Reading for a sense of the whole
2. Determining the parts: Establishing meaning units
3. Transforming the meaning units into psychologically sensitive expressions

4. Determining the structure

Reading for a sense of the whole. I read the entire transcript to gain an appreciation for the whole experience of each participant. I read each transcript through, while listening to the audio recording, three times before I focused on the written transcript alone. On the second reading, I focused on marking the transcript for emphasis, intonation, and prosody as indicators of meaning.

Determining the parts: Establishing meaning units. With the intent of achieving a more thorough analysis, each transcript was carefully read and re-read from the perspective of the phenomenological reduction. To that end, I attempted to bracket personal past knowledge and all other theoretical knowledge not based on direct intuition so that my full attention was given to the participants' descriptions of their resourcing experiences.

Prior to the start of this phase, I created a set of impressions from my experience of the interviews and from repeatedly listening to and transcribing the interviews. Undoubtedly these impressions were the intersection of my assumptions, past knowledge and experience, as well as the theoretical information I had been exposed to over my years of study and training. Before I approached the transcripts (data), I attempted to set this list of impressions aside and adopt a "beginner's mind"² or an attitude of "not knowing". The phenomenological researcher is always operating with a view to evaluating how close he or she is staying to the methodology.

² "In the beginner's mind there are many possibilities, but in the expert's there are few" (Suzuki, 2006, p.1)

Additionally, I remained cognizant that the participants' reports of their experiences might not be identical to the way resourcing was actually experienced, and I therefore, as per the phenomenological methodology, attempted to avoid an affirmation of reality (Giorgi, 2006). While remaining mindful of my quest to reveal the participants' experience of resourcing, and without adding to or subtracting from their experiences, I noted shifts in meaning. I marked shifts in meaning with a slash and highlighted meaningful phrases of the text descriptions. This step culminated in the creation of a new document: Meaning Units. All the highlighted text was transferred to this new document in preparation for the next step in analysis. I was mindful throughout the analysis that it was conducted by myself alone and therefore subject to my sole determination and reasoning.

To illustrate this step, I include the following excerpt from one of the transcripts; I have changed the highlighting of meaningful phrasing to underlining for the purposes of this manuscript:

R: What was it like for you to discover that you had that resource available?

P: .../ it felt good. I mean I didn't know that sitting on a floor with a piece of string would get me there, but I am glad it did. I wasn't just like Whoa, is this some sort of crazy magical thing, I was just like good I am glad / we found this – / probably couldn't have found it on my own

R: So you probably couldn't have found it on your own

P: No, you need the direction, you need someone else there, like you can't think it up in your own head / – it would be like him just telling me about a story of armour, I

can't just think, oh, I'm gonna have this, and I'm just gonna whip it out at any time when there something I don't agree with, right

R: So, it was really having the experience that was

P: ...even if someone typed every step up for you. Like (a self-help tape), now sit on the floor, put a piece a string around you, find your boundaries, it, it's not the same, 'cuz you are doing it on your own. You'd be like, screw this, and you'd just get up and walk away...

Transforming the meaning units into psychologically sensitive expressions. The everyday language of the participants' accounts was broken down into words, phrases, or paragraphs, which I determined had psychological meaning with respect to the children's resourcing experiences (Table 1). I also sought to make the implicit meaning embedded in the participants' descriptions more explicit. At this stage of the analysis, the participants' everyday language (i.e., language containing the implicit meaning) was transformed into statements of psychological relevance (i.e., converted to explicit meaning).

Mindful of Giorgi's (2006) caution regarding two potential errors "a) clinicians tend to pursue the personal interest of the participant too far, and b) the use of psychological jargon" (p. 253), I tried to capture both the common experience of the participants as well as the psychological relevance that might inform clinical practice. To avoid the second error Giorgi (2006) suggested a creative use of language, with careful descriptions in ordinary language rather than mere labeling.

Table 1

Selected Meaning Units Along with Empirical Variations Provided by Four Participants

Psychologically sensitive expression	Participant 1	Participant 2	Participant 3	Participant 4
Realization, epiphany, discovery, leads to a pivotal moment, a shift in perspective, an expansion of options, a discovery of the resource or resourcing nature of the experience	...that I had this boundary that I didn't realize I had before	When I am angry I can think back to that session and think about like my mellow spot and just realize that there's different options other than anger	It wasn't actually big it was just like the realizations that...I was just like...Whoa	...a turning point a moment of realization and it was really happening in the room, you really felt that in your body and you were really aware of that and the effect that THAT, what the rock represents and how that affects you

Determining the structure. Once psychologically sensitive meanings were identified, I engaged in a process of free imaginative variation. Free imaginative variation is the process that determines which of the meaning units (in this case the meaning units and their psychologically sensitive forms) are essential for the identification of the experience as a *resourcing* experience. In other words, the exclusion of one of the essential aspects no longer identifies the experience as a resourcing

experience. These essential aspects are referred to as constituents of the basic structure of the experience. Careful consideration and critical evaluation of the *resourcing-ness* of each constituent and its relationship to the whole is essential at this stage of data analysis.

The aspects of the experience, which are not essential to the structure of resourcing often comprise spatial or temporal features and are what Husserl referred to as horizontal features (Giorgi, 2009). Horizontal features help to delineate the focal experience. Stoller (2009) referred to horizontal features as “the unperceived yet nevertheless incidentally perceived aspects of the object of perception” (p. 710). Acknowledgement and review of the horizontal features is also important at this stage of the data analysis in order to provide a sense of context for the evaluation of the primary resourcing experience.

Following the free imaginative variation and the assessment of horizontal features, I created another working document in which I compiled and described the constituents of the basic structure of the experience. In a slight departure from Giorgi’s method, and in an attempt to achieve greater clarification, I tried to use both meaning units and the exact words of the participants, as well as the psychologically sensitive expressions, to expand the description and meaning of each constituent. In the following section I have used italics where I have included the words, phrases, or concepts directly expressed by the participants.

For those who described their experience as resourcing and for those who talked about what was missing from their experience, the *trying on physically* and eidetic (i.e., vivid, real) experiences occurring during the session made substantial differences. *Doing* the resource, *not thinking* it, grounding it in experience in the moment, *trying it on*, lead to the moments of knowing, with their *whole body*, their *whole being*, that a certain

rightness about the resourcing session was unfolding. Those who reported that sessions were not so helpful, addressed this essence in the negative...*too much thinking...I forgot as soon as I left the office, it didn't mean anything to me...they didn't understand, I don't think they could relate to my experience...Deep breathing was ok in the office but I wasn't upset then.*

Following the identification of the constituents of the resourcing experience, I implemented the process of reconstituting those constituents into a statement of the basic structure of the experience: the eidetic generalization. As a means of ensuring congruency between participant descriptions, meaning units, psychologically sensitive expressions, constituents, and the final basic structure of the experience of resourcing for children, I compared all the steps of analysis against the final description. I also traced each statement of the eidetic description back through the data trail to the originating participant.

Colaizzi (1978) proposed a 7-step adaptation to the phenomenological method, which included participant reviews to enhance reliability. In a significant departure from Giorgi's methodology and in an attempt to stay as close to the participants' descriptions and meaning as possible, participants received a copy of a) their individual interview transcript, and b) the meaningful phrases extracted during the phenomenological reduction and imaginative variation techniques.

The participants were asked a) to confirm my attribution of meaning and, b) if there was "...anything that I didn't get right?" and finally c) "Is there anything you would like me to add, change, correct, or remove?" At the time of writing, 8 of the 10 participants

have confirmed that a) I accurately represented their experience of resourcing, and b) they agreed with the meanings that I had selected.

Chapter Four: Findings

The findings of this study of children's experience of resourcing reflect the before-during-and-after complexity of trauma and recovery. Certain horizontal features, such as the therapist's demeanor and characteristics of the therapeutic container, were essential early in the sessions in order for resourcing to occur, and participants described a distinct after-effect of the resourcing experiences. Analysis using the descriptive, phenomenological, psychological methods of Giorgi and Giorgi (2003) revealed the constituents of the resourcing experience and its fundamental structure.

Overall, participants presented as animated, excited, and enthusiastic when reporting their resourcing experiences. However, a few participants described some neutral or negative experiences (none to any serious detriment to the participant) in their resourcing sessions. I used these few "not quite resourcing" experiences to supplement the resourcing descriptions. I have included some of these experiences as an illustration in the following sections. Hearing about how resourcing was *not quite*, provided a valuable perspective on what resourcing *was*, and helped me during the analysis to learn more about the boundaries and distinctions of the experience.

Participants' descriptions were analyzed for common constituents based not only on the transcribed written responses, but also on the emotional tone and valence relayed to the researcher. Therefore, joy or triumph, for example, may have been made apparent by inflection or delivery whereas the quote, as written, did not necessarily by and of itself convey the entirety of the emergent constituents.

I am mindful that traumatic experiences are often more than a single isolated event. A person traumatized by an event carries a history of life experience, which includes a set of self-referent beliefs, which may be loosely or more rigidly formed by time and repeated experience. Additionally that person possesses a set of skills at varying stages of mastery, as well as a set of relationships with others from immediate family expanding outward to extended family, neighbourhood, community, school settings, society, and culture. All of these factors influence a person's reaction to a potentially traumatic event.

Hence, pre-existing life experience and current circumstance interact with a traumatic event(s) and the interplay between these factors influences the overall impact on the individual. This impact can, at times, be of such intensity as to overwhelm the person's defenses and coping measures.

A spectrum of traumatic reactions commonly occurs, ranging from developmental wounding and single incident acute trauma, to chronic trauma resulting in complex PTSD. Immediate and ongoing post traumatic circumstances influence how the trauma is integrated (or not) into the person's identity and worldview. The impact of any event is a complex interactive sequence with many variables. Some consequences of trauma are predictable as they repeatedly manifest; others are unique to each person and situation (Ogden et al., 2007; Tinker & Wilson, 1999).

Therapeutic Relationship and Container

The term therapeutic relationship refers to the interrelational qualities between the client and therapist, while the term therapeutic container refers to the spatial and environmental aspects within which therapy occurs. The therapeutic relationship and

container do not represent a constituent in the experience of resourcing but serve as what Husserl called horizontal features (Giorgi, 2009).

Horizontal features, once again, are aspects of the experience that occur around the intentional object of focus, in this case the experience of resourcing (Giorgi, 2009). Anything that occurred surrounding the experience of resourcing is considered to be a source of additional data and worthy of analysis. Horizontal features help delineate and define the intentional object and add substance to the experience of resourcing in a compare and contrast manner. While not a constituent of the resourcing experience itself, resourcing would not have occurred if the horizontal features of therapeutic relationship and container were not in place.

Participants' descriptions included some indication of the necessary constituents of the therapeutic relationship and container, reflecting the personally relevant concerns or conditions that related directly to the resourcing experience. While such constituents do not amount to a comprehensive account of the basic structure of the therapeutic relationship, as a prelude to understanding resourcing itself, it seems reasonable to explore, "What therapeutic relationship and container aspects need to be in place in order to make resourcing possible?"

The participants offered several ideas toward answering this question and I have chosen to retain the voice of the participants as though addressing the therapist in the following statements. The italicized text below is the result of the analysis of the participants' own words using free imaginative variation, a component of the phenomenological methodology.

Free imaginative variation, to review, is a procedure that examines the difference between the individual data and the more general psychological meaning. It is the product of the analysis of the raw data at a level that derives psychological meaning for the benefit of the discipline (Giorgi & Giorgi, 2003, pp. 355-356).

The italicized text below is the participants' data reworded into phrases that reveal the meaningful components of the therapeutic relationship and container. The text represents a merger of participant voice and psychologically sensitive expression as if the participants were talking directly to the therapist:

- *Your trustworthiness influences my ability to be open and honest about what troubles me. How the session goes hinges on my sense of your trustworthiness.*
- *Your early attention to my worries or nervousness regarding what is going to happen in the session, what you expect of me during the session, and what I can expect of you during the session, and maybe even outside the session, is important. I base my ideas about your trustworthiness on what and how you convey this information to me. Doing this allows me to engage with you in the session.*
- *When you are calm and comfortable in yourself, it helps me be calm and comfortable with you and also in this setting. This also helps me know about your trustworthiness and my safety.*
- *When you are genuinely and authentically caring, understanding, welcoming, and patient it soothes me and creates an opportunity for me to*

engage, lower my defenses, feel safe and even be curious about my situation, responses, reactions, and, especially, solutions.

- *When you convey genuinely and authentically that you are prepared for pretty much anything, open to pretty much anything, and are perceptive, and I experience you listening carefully to me, I feel a sense of safety and trust, as well as curiosity and openness to possibilities during our sessions.*
- *When you adopt an attitude of non-judgment, non-telling, non-teaching, and non- pressure I am better able to collaborate with you.*
- *When you are attentive, reflective, and act as an extra set of eyes, you offer me valuable information with which I can evaluate my experience, make adjustments to my responses and reactions and discover alternative perspectives to my situations and issues.*
- *When you act as a guide, provide me with lots of choice and control, make relevant suggestions, and convey that I am viewed as competent and capable, I am more likely to participate in my own therapy and collaborate with you in the process.*
- *If I get the sense, or for some reason believe, that the session is more about you than about me, I will disengage and have difficulty trusting you.*

An Eidetic Generalization of the Resourcing Experience

The application of Giorgi's (1997; 2009; Giorgi & Giorgi, 2003) method of descriptive phenomenological psychological analysis revealed the basic structure of the resourcing experience. Giorgi's (2009) assertion was that if you have adhered to the method you would have revealed the basic structure of the phenomenon. Presented here in its entirety is the final product of the analysis and an explanation of that structure (P = participant).

For P, who is a traumatized young person and who is attending trauma therapy, the resourcing experience begins with contact with a therapist who conveys trustworthiness. A major component of the development of trustworthiness is the therapist's early explanation of the purpose, goals, process, and expectations for the session as well as for therapy in general. These explanations include what is going to happen during the session, what the therapist expects of P, and what P can expect of the therapist during and outside the session.

Another component of the development of trustworthiness occurs when P typically assesses trustworthiness and safety by observing and sensing the therapist's calmness and comfort and by the therapist's manner and presentation. P takes note of physical comportment, as well as tone of voice and choice of words. P seeks a therapist who is genuinely and authentically caring, understanding, welcoming, and patient. These qualities in the therapist help P to decrease his or her nervousness and uncertainty.

P seeks a therapist who is attentive, reflective, and acts as an extra set of eyes (so to speak), rather than one who interprets P's statements, actions or intentions. P can be

guarded and defensive, and is fearful of judgment, being lectured or directed, and being pressured to perform in the session.

Finally, P requires a therapist who is a guide, who provides choice and options for control within the session, and who consistently conveys to P that P is seen as a competent and capable person and a collaborator in the process. For P, the sense of being seen as capable and competent establishes a positive and hopeful tone from the start of the resourcing session. The therapist's non-judgmental attitude gives P a sense of hope, esteem and value.

The negotiation and selection of the specifics of what to work on and how to work on it are mutually agreed upon after the therapist grasps the context and unique circumstances of P's situation. P seeks a relevant solution or resolution to distress related to a particular situation or event.

P feels some urgency in dealing with present day hassles and frustrations which may not be directly associated with the traumatic event/situation. In response, the therapist does not re-direct the focus of the session to what the therapist thinks it should be, despite the fact that the connection between the present day hassles and frustrations, identified by P, and the traumatic event or situation, may be obscure to the therapist.

As the resourcing process unfolds, P has an ongoing need for choice and control of the decision-making. A calm atmosphere and a calm internal feeling-state lower P's defenses, which in turn allow P to be open and curious about the unfolding experience.

P begins to physically try on, or vividly explore, alternative perspectives, as if for real. P repairs or establishes personal boundaries, gains insights, discovers or develops

personal abilities, or connects to relationships that feel right. Such pivotal moments frequently result in a change of perspective, a sense that time and space are more expansive, with more options being available, and a sense that clarity is being gained on the issue.

P begins to feel intrigued, satisfied, relieved, *crazy sooo good, very chill*, or even joyful. In a pivotal moment, P feels a triumphant sense of accomplishment, which leaves P feeling calm, confident and happier.

For P, there is surprise and delight due to the ease at which such a discovery occurred. Something inside P feels different; something fairly deep has changed through this resourcing experience; interestingly, so has the intensity of the traumatic material, which may remain, but is not as bothersome or disruptive. Often, there is a lingering effect from the resourcing process over the following days, and sometimes weeks, as P notices a *betterment of the problem, of me and even of everyone around me*.

P gained this insight by having a guide and feels empowered by the sense of accomplishment. The experience leaves P with the sense that, *I actually figured it out myself or I came to it on my own*. Yet there is simultaneously a keen awareness that, *I could never have done it without you*.

I considered all of the participants' transcripts as being one whole body of data. Their expressions appeared as a collection rather than each participant's words standing alone, therefore, the constituents of the resourcing experience were expressed collectively rather than individually. It seemed that the participants required all of the essential constituents

(discussed in detail below) for them to enter a therapeutic session and in particular resourcing sessions.

Participants who reported a less than satisfying resourcing session were articulate in their descriptions of what was not right for them about their sessions. For example, *I felt like she judged me...she told me I was not thinking right...she said I just needed to learn deep breathing and understand my triggers, I didn't get it...it was like she had some idea about what I should be doing differently and I didn't get it.*

I had considered removing these few interviews from the data pool but I realized that these descriptions contained a valuable perspective: that of what resourcing is not. This allowed me to gain important insights, particularly during the step of free imaginative variation, where both the hits and misses of resourcing efforts made the essentials of the basic structure clearer and slightly more precise.

Constituents of the Resourcing Experience

I will turn now to a discussion of the constituents of the basic structure of the resourcing experience for children/youth, before returning to the experience as a whole. Also presented here, in the order that they appeared, are the 12 constituents determined through free imaginative variation, which are as follows:

1. Perceived attitude of the therapist
2. Personal and contextual relevance
3. Currency
4. Choice and control

5. Calming
6. Unsticking
7. Experiential and embodied
8. Triumph
9. Internal ease
10. Needing a guide
11. Naming
12. Betterment

For each of the constituents, presented in detail below, I have included supporting meaning units taken directly from the participants' interview transcripts.

Perceived attitude of the therapist. The messages conveyed by the therapist play a pivotal role in establishing the tone for the resourcing session. Participants described being uncertain and nervous when initially approaching therapy and the resourcing sessions. Hence, not being judged by the therapist was important for their feelings of trust and safety in the office environment and with the therapist.

It was also important for these participants to be viewed as capable and competent. When they felt, sensed or otherwise believed that they were seen in this light, the session moved rapidly and easily towards resourcing rather than activating a defensive stance in the participants. The statements that follow are taken verbatim from the participants.

- *You didn't feel like she was judging the situation; but I could say I could tell her anything because I knew she wouldn't judge me*
- *I was nervous because um, I don't like opening up to people usually, but throughout the thing I did open up to him and that was good, but at first I was nervous and I thought it was going to be awkward and I was just paranoid about it. Explaining to me what would happen, what would go on, and why I was there...it calmed me down*
- *Judging um, forcing...I don't know – thinking they're right all the time...I don't know what to call it...they just didn't listen really well*
- *Trust is gone, so you won't be able to take it where it needs to be or where it could be*
- *...because it was explain[ed], I knew what was up If someone said do that...I'd probably be like, no, why don't you do that...like tell me why first – so it's better just to not be thrown into something*

Personal and contextual relevance. Participants were especially keen to find solutions or resolutions to distress resulting from current and personal experiences. They did not respond especially well to generalized approaches and interventions that appeared to participants as “one size fits all”. While they could relate to suggestions that had worked for others in very similar circumstances, commonly they responded more positively to the therapists who acknowledged them and their circumstances as unique.

- *I want help with what I want help with; what I am trying to work towards. I don't want to hear about when she was young it worked this way or that way...that might not work for me*
- *I remember her being like it works for some people and it doesn't work for others, she was like you can try this if you don't mind trying this*
- *But it was like, yeah. It was nice that she'd tried it before with other kids and she knows that it works and so I was like ok*
- *He didn't put ideas in my head about what I needed to work on; he let me come to that conclusion by myself*
- *I don't remember the other ones [options] cuz I didn't really...once I heard that good one, I was like let's go that's it!*
- *I chose what I thought was most suitable and then went from there and came to a conclusion to what I had to work on*
- *It was like (indicating the space around her) yep, this is it, this is just right...and like there you go...I'd be like...he'd try to move a piece and I'd be like hey put it back...that is not right; he would just throw out suggestions, but like not for me, but like examples...It helped me explain it to him more; more relevant, more real; if he understands more of what I want help with and what I am trying to work towards, he'll understand more how to help me; not so superficial; makes it more personal which I appreciate*

- *He asked me to do it [‘it’ being to imagine taking on the characteristics of] with an animal, but I couldn’t really relate*

Currency. Currency is used here to reflect the dual qualities of present time orientation and value for one’s effort. Several participants and many of the therapists began the session thinking that they were going to work directly on resource development specifically related to the traumatic experience (e.g., sudden loss of a parent, dramatic suicide of a close friend, acrimonious divorce and custody battle, car accident with family member’s death). The participants, however, clearly expressed the view that what they preferred and needed to work on were present day stresses and tensions. Often, the issues of immediate importance to them were not overtly associated with prior traumas. Despite the lack of a direct association, they later reported that resourcing present day issues reduced their current symptoms and feelings of disturbance that were consequent to the traumatic event.

- *I was gonna go in there and talk about my dad. I don’t know but it evolved into something totally different than what I was expecting. Everything with my mom is probably more important; it was just what jumped out at me*
- *...he asked like what I wanted to work on and it might not necessarily be the most tragic, cuz like [my friend] thing was probably...but I just thought it made more sense to do what was probably the most influential like on your daily life*

Choice and control. Those participants who were repeatedly presented with choices ascribed positive outcomes to their sessions. For them, choice was an integral part of the focusing of attention and the fine-tuning of the relevancy of activities throughout the

resourcing sessions. Having choices helped participants gain a sense of control in the process and further helped them to develop confidence in their abilities to make decisions.

The few participants who reported neutral or negative responses to their sessions, reported that they felt as though they were *being told* what they needed to do, in the session, in their reactions to traumatic experience, and in their lives generally.

- *...he didn't baby me. I felt like an equal almost, like he was there to help me but he didn't treat me like I was five, which was nice. Like we [I] said before, try not to tell them what to do, like offer it and give examples like...choices, suggestions, that kind of thing...a little control in what's going on...different suggestions instead of, like, do this. It was nice to be able to choose if you want*
- *I don't know why, I just felt like I needed to push certain spaces away, like I don't know why, but it definitely made me feel more comfortable and I had my control and I had the um, had the control to be, to make it what I wanted it to be*

Calming. Being relaxed and calm were valued when receiving explanations, as were being given choice and control, and being genuinely heard. Calmness was associated with the therapist's manner. These physiological and feeling states were emphasized in the participants' descriptions from early in the sessions. As sessions unfolded, participants began to understand and realize, internally and externally, that they could improve their situations. A calm state also had beneficial effects during experiential exercises conducted within sessions.

- *I don't know, just your eyes...I don't know, I remember my eyes just felt more calm. It was just when she brought me to the mellow state...my whole body, it just felt like it was...free.*
- *I got more comfortable and I would mellow down a whole lot*
- *...bring me to a place that I was at, like all mellow and stuff and she was able to talk about what was really important stuff, so...it wouldn't have happened without the session or without [the therapist].*
- *It's like I am on a water ride at Disneyland and we are just going through the town; yeah calm...it's just kind of a very relaxed place...it is not like you are disconnected from the world it is just like relaxed...not excited, not not excited...like very chill feeling*
- *...aware of everything going on just like, really like chill or calm just helped rather than having someone like really uptight I guess*

Unsticking. The effects of the calm and relaxed, chill, or mellow states reduced stress, and the reduction of stress led to a reduction of the influence of the traumatic event. This appeared to shift their perspectives, from being “stuck” with an awful memory or situation to being open to alternatives, or “unstuck”.

- *I don't know evolved into something totally different than what I was expecting. I could see past it.*
- *Definitely a different perspective on it*

- *I have just thought of it from day to day and the arguments aren't as bad anymore, I guess, because its constantly in my mind that there is a different place that you can go to besides 0-80 [miles per hour] anger*
- *...help you either cope or manage or make it less stressful*
- *I just wasn't stuck on it for some reason. I could move on and not have to dwell on it.*
- *I said well I don't know, I feel just like really relaxed, like he could tell, my body language, I was just very not slumped over but just like, like, in a comfortable position*

Experiential and embodied. A notable difference between those who responded well to the experience of resourcing and those who did not was whether or not the trying on of physically and eidetic (i.e., vivid, real) experiences occurred during the sessions. Participants described that trying on or *doing the resource not thinking it*, helped anchor the experience in the present moment. This anchoring led to moments of deep knowing, with their whole bodies, their whole beings. They reported a certain rightness about the resourcing session as it was unfolding.

In contrast, those who reported that sessions were not so helpful, addressed the lack of such experience in the negative: *...too much thinking, I forgot as soon as I left the office, it didn't mean anything to me or They didn't understand, I don't think they could relate to my experience or Deep breathing was ok in the office but I wasn't upset then.*

- *...taking it on and you are actually really feeling it for yourself*

- *I knew it felt right cuz...you're, you're just content with where it is. It just felt good; your whole being knew where that string should be; it was like (indicating the space around her) yep, this is it, this is just right...and like there you go...I'd be like...he'd try to move a piece and I'd be like hey put it back...that is not right*
- *It was really happening in the room, you really felt that in your body and you were really aware of that and the effect that THAT, what the rock represents and how that affects you*
- *...that really helped was pushing, physically pushing you know it out. Well I felt, you know strong, I felt like... So that really helped*
- *I can actually physically do it; makes it more... relevant real more*
- *I think physically touching the things and placing them where I needed them to go and physically moving the string and physically touching it and figuring what my space was instead of imagining it, cuz if I would have imagined it, I wouldn't have actually put myself in the situation and I wouldn't really have tried to figure out what my space was*
- *If I just looked at the negative and like who was bad in my life, I wouldn't, I would feel almost like I didn't have any good like it was all negative. Whereas I think it is important to try and I don't know, make me remember what's good and what's really there*
- *And that was kinda cool and it kinda like physically you could just let go*
- *...made me think about it more and I guess not physically actually letting it go but just the action of doing it might have affected me more than just saying like ok it's*

gone; really focus and just like...let it go and, mmm, it was different but I think it worked too

- *And once you have that you can't not have it; whereas if it was just an idea it could go away*

Triumph. Eidetic and lived experiences were crucial to providing the impetus for realization, discovery, or epiphany. Such moments resulted in clarity, a shift in perspective, and a sense of time and space being opened up. During the resourcing experience there were often such pivotal moments when participants felt an awareness of themselves and their connection to the world that was somehow different than before. They described these experiences in different ways: *very chill, intriguing, satisfying, a relief, joyful, and crazy sooo good*. Such shifts evoked a triumphant sense of accomplishment, which in turn led to greater confidence, optimism, and a generally happier outlook. Note once again, that these statements taken collectively convey the constituent, not the quotes in isolation.

- *realize how I can live my life better*
- *Somewhere where you can pull things out of you, pull different areas that you didn't know you had, different mechanisms methods to get out of them and they had a resource. They teach you ways that you can deal with things that you didn't know you could do before*
- *You could really envision it; it was like totally putting it into perspective; a turning point a moment of realization*
- *...you get to test it*

- *It can also help you realize things you didn't know before things you didn't even know you wanted to talk about, things are interconnected help you talk about stuff that you didn't even know was bothering you. I didn't even know that that's where I got it from but it was. So it makes you realize things you didn't know*
- *...good, I felt soo relaxed after; I just felt so relieved. Like it was crazy how relieved I felt. Just like...I wanted to keep...like he asked like how I felt and I was like sooo good...I know what I'm doing now.*
- *it wasn't actually big it was just like the realizations that... I was just like...Whoa; I came out with a whole bunch of things that I didn't really think about before; What's the word? It was an epiphany*

Internal ease. Participants were often surprised by the ease at which such positive shifts occurred. They were also surprised by how obvious their discoveries were once they made them. They wondered if they hadn't had them all along or whether they were something new. The experience was felt at a different and deeper level, and they reported that it was definitely something that was inside them.

- *I thought it was really interesting how it works and how I felt sooo much different by doing that*
- *It wasn't as hard as I thought to just like push them out*
- *It wasn't new information, but it brought it – it made it come to the surface – to help me realize that that was there*
- *I was getting to a different level and it was really like there all along I guess*

- *...figuring it out myself; making my own decisions and deciding what was what and what I um, what I wanted to get out of it and then that relief at the end, I finally, I've gotten what I needed to know...and it wasn't even hard*

Needing a guide. While there was a sense of accomplishment described as, *I actually figured it out myself* or *I came to this on my own and did it myself*, at the same time there was the awareness that *I never could have done it without you*. One participant said *if you'd have written out all the steps and then I went away and did it by myself...I never would have gotten this!*

- *You need the direction, you need someone else there, like you can't think it up in your own head – it would be like him just telling me about a story of armour, I can't just think, oh, I'm gonna have this, and I'm just gonna whip it out at any time when there [is] something I don't agree with, right*
- *...and PICK it for yourself – he didn't pick it for me...I picked that too; that one I knew right off the bat; yeah it wasn't a mystery of words*
- *It's almost like I figured it out myself; like he didn't figure it out for me, I did it myself whereas if he told me what was what I wouldn't have figured it out myself and I wouldn't feel so good about it, I wouldn't feel so relieved about it; I said, I feel pretty good like I can go out and do things now*
- *We addressed the issue, we completed the issue, we described the issue, we figured it out, you know and then what else do you do? You'd need a new problem to talk about*

- *Cuz it is good to have someone else to talk to cuz she's an outside person who doesn't know anything about my life – but she was able to bring me to a place that I was at, like all mellow and stuff and she was able to talk about what was really important stuff, so...it wouldn't have happened without the session or without [the therapist]*

Naming the resource. Participants named resources by identifying them as a variety of things to be built up or developed, (i.e., a quality, skill, ability, or relationship). They sometimes wondered if a resource was something singular or if resources might be a *package deal* in which one realization and shift in perception/perspective leads to associated resources, which could be transferable to other situations.

- *It is a skill...finding those things, or making them stronger...you know there should be an Olympics for this...You know...I can whip out my armour...look at you, you've got your force field and she over there has her pink pom poms*
- *Something that you have or discover, could be both, you know, that you personally, like, not everyone's resources – in this type...we are not talking about like financial resources here – in this type of thing that we are talking about...not everyone's is the same but it is something you can use for yourself...whether it is to protect yourself, or bring yourself back to reality...you use it to evidently benefit and better yourself...*
- *People probably have different resources and you could have multiple resources you don't just have one but it could probably function in lots of situations and not just one*

- *I think you develop it...like you kind of have it but it is under something that won't be lifted over time...it needs to be brought to you*
- *It's a skill and um not necessarily the maturity or the will power not to fight. I'm just not even going to do this; I am not going to react. I'm not going to give her the reaction she wants, I guess. Just be mature too and just being able to walk away. So I guess it's a skill that you actually have to learn over time*
- *Understanding where someone else is coming from, and not over reacting to situations that aren't worth it, and if I ever get frustrated, just take a step back and think about it, and it's not the worst thing in the world and it will blow over, so just think about the situation before you react – so I could apply that to a lot of different situations for sure*
- *A solution...a way of thinking – you develop a new perspective on your whole situation. I feel like I developed it as a mindset. I think it's learning something new about yourself. Resourcing is something you don't have but in the resourcing session you are able to find a way that you actually have it. You actually have it but you just don't know about it so in the resourcing session you work on it and then you realize that you have it and there it is...It just made me feel really comfortable*

Betterment. Finally, participants described a lingering effect over days or even a few weeks. The effect included the *betterment of the problem, of me and even everyone around me*. Participants explained that the resourcing experience hadn't necessarily

taken away the traumatic event; however, they described the incident as less bothersome, less concerning.

- *I have just thought of it from day to day...basically every day...and the arguments aren't as bad anymore, I guess, because it's constantly in my mind that there is a different place that you can go to besides 0-80 [miles per hour] anger*
- *Everyone's life is better...there's a little ripple effect; I look at them different*
- *...since I've done it, I feel more confident all – all the time*
- *...it's not going to be the driving force that changes your life in a person but it is something you can kind of whip out of your back pocket when you need something for yourself*
- *...then you go retrace your steps back...not back to the problem uh back to the betterment of the problem*
- *...because of the skills I learnt and I am sure that by putting the skills into play and that it will get lower and lower and lower until it's like not an issue anymore*
- *With more practice and use of my resources, it might not be an issue anymore at all*

Exploring “I Don't Know...But...”

Extraneous to the fundamental emergent constituents, yet still of interest, were participant responses that began with “I don't know...but...” These responses were actually very informative, if the opportunity to explore the “but” was taken up. This

response showed up most often to the question, “How do you know?” or “What led you to think (believe, feel) that?”

The descriptions and explanations provided following “I don’t know but…” were rich and thoughtful even when participants struggled to find the right words.

- *my whole body told me or my whole being just knew it was the right way to go*
- *I don’t know I just...I kept like I kept adjusting...I don’t know why, I just felt like I needed to push certain spaces away, like I don’t know why, but it definitely made me feel more comfortable and I had my control and I had the um, had the control to be, to make it what I wanted it to be*
- *[I] felt relieved almost; like this is exactly where it should be; relief...there was a lot of that feeling*
- *I don’t remember the other ones cuz I didn’t really...once I heard that good one, I was like...whatever*
- *Oh I just really understood it; there was a realization that came from within; It was just a click*
- *I don’t know, I just felt like the second one that we talked about was better and it would make me...we talked about it would be more...like...it would just help like way better. I just knew that if we talked about that it was gonna be better*

- *I said well I don't know, I feel just like really relaxed, like he could tell, my body language, I was just very not slumped over but just like, like, in a comfortable position*

Limitations

The process of research design and implementation necessitates that the researcher make decisions, which inevitably require an acceptance of inherent limits. From the very first step in the research process where the investigator must hammer out a research interest, or even multiple interests, into a researchable problem, through to the development of a research question, the researcher makes choices, which create a research context. This process includes the determination of methods, the acquisition of data, the analysis and interpretation of data, and some form of confirmation or rejection of the findings through a review by others.

The goal of this study was to gain access to, and a sense of, the particulars of the resourcing experience of children in individualized tri- phasic trauma therapy. I determined that this was best achieved using a qualitative approach. I adopted a phenomenological stance in order to get close to the 'whatness' and 'howness' of the object, resourcing. I selected interviews as a means of gathering data, but as part of my findings, I have determined that the enactment of this methodology presented a number of limitations.

The first limitation is that the methodology is based in philosophy rather than actuality and is dependant upon interpretive factors such as the medium of communication. The phenomenology of Husserl is philosophical rather than psychological. His pursuit of universal essences in experience may strive for an ideal that cannot be reached when one

shifts to a psychological application. Furthermore, a consistent critique of phenomenology is that it fails to consider the discursive nature of experience.

Husserl was not very interested in how certain experiences were influenced by language or the execution of language. Stoller (2009) posits that Husserl might have underestimated the full significance of language “as a constitutive, normative element that creates meaning” (p.722). I wonder if in part, Husserl was not more preoccupied with addressing the empirical concerns of the day, prior to the post-structural turn, as he seems to have taken great pains to explain phenomenology in an empiricist-friendly manner.

Giorgi (2009) addressed the language issue by explaining that since there is no direct access to the experiential world of the participant, it must therefore be accessed indirectly through some form of expression. He stated “there are many forms of expression from concrete behavior to artistic, and each has its own set of peculiar difficulties with respect to the assessment of the participant’s experiential world” (Giorgi, 2009, p. 107). He acknowledged the privilege that language receives, yet argued that it did not hold an exclusive place with respect to the determination of the world of another, in this study, the child-participant.

Giorgi (2009) further explained that from the Husserlian perspective the description provided by participants, although it is transcribed and possibly printed, remains a description. Finally, he asserted that not everything that is written down constitutes a text in its strictest sense, since there are “many modes of reifying and communicating language nonverbally” (p.126). A text that requires interpretation has some form of

ambiguous features and often these ambiguities refer to the horizons of the text rather than the text itself.

Clearly, philosophical positions as well as methodological perspectives are open to intense debate. In the end, the researcher must weigh the issues and make a decision in order to proceed. In the case of this study, I decided to involve the participants after the extraction of the meaning units, in order to clarify that their descriptions were accurate reflections of what they had intended.

The second limitation of note is that of the researcher herself, as the ultimate arbitrator of the extracted significance and its relevance to the discipline. Attempting to delineate “something as something” is never free from interpretation, nor is it without historical perspective or unmediated (Stoller, 2009).

The modified Husserlian phenomenological psychological method advanced by Giorgi (1997; 2009), proposed the phenomenological reduction to better filter this interpretive aspect. This included an attempt by the researcher to bracket past personal and theoretical knowledge of the phenomena, which Giorgi and Husserl viewed as being horizontal features.

Giorgi (2006) differentiated his descriptive methodology from alternative schools of thought, such as the interpretive/hermeneutic, constructivist, or explicative approaches (i.e., non-Husserlian phenomenology) and affirmed, that while there is participation by the researcher in his methodology, it does not meaningfully take place until analysis begins. Where, for example, an interpretive perspective would view each interview as a co-creation between researcher and participant, which they refer to as a "text", Giorgi's

perspective was that each interview represents a natural attitude, an everyday description of the experience of the phenomena, in this case resourcing.

Giorgi's methodology considers each participant's description as raw data and importantly, data to which nothing is added, or subtracted. Giorgi's view, following the work of Husserl, was that essential characteristics were concrete data and that any knowledge gaps were suggestive of the need to gather more instances of the experience (Giorgi, 2009).

The intent was to observe the description of the phenomenon as it was given in the present. How well and to what extent an individual researcher is able to accomplish this task is determined by a combination of ethical and personal abilities as well as the researcher's experience with detachment or dual awareness.

Giorgi acknowledged that two strategies have arisen in recent years whose intention is to enhance phenomenological reliability. The first strategy requires that a panel of judges conduct an external review of the material in addition to the analysis done by the researcher. The second strategy requires that the participants of the study verify and correct the researcher's findings. Giorgi asserted that "both strategies are misguided" (Giorgi, 2006, p. 357) and recommended a strict adherence to purely phenomenological methodologies.

External reviews, he suggested, derive their structure and methodology empirically. Such reviews tend to marginalize qualitative, phenomenological procedures, ideations and motivations in order to arrive at a consensual reliability that is not manifestly a genuine reliability. Giorgi further remarked that participant reviews, a procedure proposed by Colaizzi (1978) as part of an adaptation to the phenomenological method,

were of doubtful value. Giorgi restated that the phenomenological methodology requires that the researcher perform the analysis using the expertise of his or her particular research discipline (e.g., trauma counselling) adding, “The purpose of the research is not to clarify the experience that the individuals have for their own sake, but for the sake of the discipline” (Giorgi, 2006, p. 358).

Giorgi also acknowledged the role of the ‘critical other’. The critical other represents a hypothetical researcher, a critic, evaluating the same material. The critical other, knowing the method, should be able to step into the researchers shoes and reasonably understand the researcher’s findings and conclusions. The researcher is not responding, in the analyses of the data, as an individual, but as the representative of a community that includes the critical other.

I carried three critical others with me through this process. The first was imagined to be the participants such that I would ask myself, “Am I remaining true to their descriptions, their experiences? Am I adding or taking away?” The second was envisioned as my professional colleagues and were represented by the question, “Am I consistent with the principles, practices, and general understandings of trauma therapy?” Finally, I brought along the research community, philosophers, theorists, and academics to whom I might be required to answer.

Having reviewed Giorgi’s methodology and alternative schools of thought, and ever mindful of the critical others and the phenomenological exhortation to describe rather than explain, I have evaluated and adapted my methodology to include participant confirmation of the transcripts and meaning.

I conducted this study to create an opportunity for children to participate and bring forward their voice regarding their experience of resourcing in the context of individualized tri-phasic trauma therapy. I did this with the hope of bringing the children's perspective closer to the therapist in a way that therapists could easily understand and immediately apply in their own practices. Although I conducted this study within the parameters of science, and held the philosophical principles and methodological processes foremost in my mind as I carried it out, it must be said that the extent to which I was successful is open to discussion from many perspectives.

Chapter Five: The Voices of Children – Ideas, Investigations, and Implications

The constituents, which emerged from the phenomenological psychological analysis of the data during this investigation, revealed a fundamental structure in the children's resourcing experiences during clinical trauma therapy. Since a review of the literature on resourcing revealed no previous studies, qualitative or otherwise, with a primary focus on children's or youth's experiences of resourcing, the wealth of information provided by the participants has opened the door to further research.

The addition of the client's voice has revealed areas where the therapist might improve the reception and efficacy of therapy by refocusing resourcing efforts to target those areas that are potentially more meaningful and helpful to the client. In my final departure from Giorgi's methodology, which culminates with the eidetic generalization of the studied phenomena, I have added this discussion chapter for the benefit of those who work in the clinical field, and for those who might consider further research on this topic.

Implications for Clients and Practitioners

Client focus – resourcing in the foreground of client awareness. The data analysis suggested that two closely related aspects co-exist in the experience of resourcing: the first at the level of the therapeutic relationship and therapeutic container, and the second at the level of the resourcing itself. The overlap or intersection of these levels was most apparent in the first four constituents revealed through the use of free imaginative variation, which were (a) perceived attitude of the therapist, (b) personal and contextual relevance, (c) currency, (d) choice and control.

I returned to the experience as a whole and when I did so, I found that aspects of the therapeutic container, therapeutic relationship, and these constituents could not be easily

separated out in the experience; that levels of resourcing could not occur without a certain level of therapeutic relationship and container in place. My sense is that these levels are dynamically related and that their relative importance vacillates throughout the session. I am reminded of Merleau-Ponty's ideas about foreground and background (Hass, 2008):

To see an object is...[to] become anchored in it, but this coming to rest of the gaze is merely a modality of its movement: I continue inside one object of exploration which earlier hovered over them all, and in one movement I close up the landscape and open the object. The two operations do not fortuitously coincide...It is necessary to put the surroundings in abeyance the better to see the object, and to lose in background what one gains in focal figure (Merleau-Ponty, pg.67)

Directing attention to resourcing positions it in the foreground and the therapeutic relationship and container fall slightly out of focus and nestle in the background, but they remain interdependent. I hypothesize that the same is true for the traumatic material itself. As the resourcing experience comes more sharply to the client's attention, so too, the details of the trauma can often fade, if momentarily, into the background.

The hope for resourcing is that the potential for healing and change in the present takes center-stage in the child's consciousness, when attention is repeatedly but gently brought to the resourcing process. This directs his or her thinking away from replaying traumatic events by putting resourcing in the foreground and allowing the trauma to temporarily become blurred background. Gradually identity shifts away from that of traumatized victim and toward a sense of a competent and capable person in the present.

Participants indicated that resourcing during the safety and stabilization phase of the tri-phasic approach to trauma therapy was especially helpful when it was centered on present day concerns (which may be indirectly related to a traumatic incident). In several instances, participants and therapists began with the idea that appropriate resourcing would be directly related to the traumatic event. However, some participants redirected the focus of the resourcing to current, but indirectly related areas of concern. For example, a participant who had thought that she would work on the sudden and violent death of her father revealed that when negotiating the session the therapist also suggested working on something around that event; however, the participant insisted that she realized then and there that working on her relationship with her mother, which had changed since the death of her father, was more important and relevant and that working on her father's death would be "easier" if the issue with her mother abated first. Another participant recounted that her therapist (a different therapist than the one above) seemed to direct the participant's attention to the event and to think about what she might need to help her cope better with the sudden angry feelings she felt were taking her over at times that she felt were unrelated to the traumatic event. This participant reported that she kept going back to the recent times she felt these seemingly out of context feelings until the therapist agreed to work on the participant's current concern rather than return to the traumatic event.

For the therapist, the implications of the client's shifting focus suggest that key initial steps at this stage of the resourcing experience might best include efforts devoted to meeting the client's expressed current needs. Although the temptation may be to continually redirect the client's focus back to the traumatic material, strengthening what

resources are already in place, and promoting the client's well being in his or her current circumstances, seem to achieve the therapeutic goals of increased competence and connectedness.

Proceeding immediately to traumatic material can increase the risk of destabilizing a person already struggling. Additionally, it is contrary to the tri-phasic convention of leaving the re-processing of traumatic material for the second phase of treatment.

By allowing the focus to shift to current situations and stressors for resourcing sessions, resourcing is placed in the foreground while traumatic material is temporarily situated in the background, becoming a part of the context until the foundation for trauma processing is established. For example, clients who present with a fair degree of arousal of the autonomic nervous system subsequent to a traumatic experience, can benefit from resourcing for the arousal that is manifest in present day situations (such as frequently needing doctor's appointments, or struggling with a persistently over-protective parent, both of which may actually be the indirect result of the traumatic event). Once clients can use their resourcing experiences to stabilize their hyperarousal they have a valuable and broadly applicable tool for further trauma processing.

Therapeutic relationship and container: The background. A significant challenge for therapists is always the creation of both a relationship and a therapeutic container that best facilitate the process of resourcing for each unique client. A typical one-hour therapy session consists of a beginning, middle and end segment, of roughly 20-minutes each. My research indicates that the participants felt the therapists' influence most heavily in the first part of the session and this insight is useful for clinicians who can

choose to mindfully shape both the therapeutic relationship and the therapeutic container when they are in the foreground of the client's focus.

From there, the therapists shifted gently from leading and negotiating to guiding and accompanying clients during the middle section of the session. In the final portion of the session, therapists assisted their clients with solidifying the experience, savouring the newly learned perspective(s), and deciding how to best integrate the experience into their daily lives. During the middle and end segments, the clients' focus shifted to allow the therapeutic relationship and container to provide the comforting backdrop that supported the resourcing activities.

Janet (1924) had long identified that the patient-therapist relationship deserved special recognition. He proposed that rapport could be used to foster the patients' independent actions (van der Hart et al., 1989). Current research on the relationship between clients and therapists in child psychotherapeutic settings indicates a moderate and consistent contribution of the therapeutic alliance to positive outcomes (Gaston, 1990; Janet, 1924; Martin, Garske, & Davis, 2000). Additional support for the value of the therapeutic relationship and container is mentioned in research for children with anxiety, adolescents with depression (Shirk, Gudmundsen, Kaplinski, & McMakin, 2008); and adolescents with oppositional, aggressive and antisocial disorders in CBT-type treatment relationships (Kazdin, Whitley, & Marciano, 2006).

In the recent literature, Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) explored the variables of therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. This research group was

interested in the contribution of therapeutic alliance and negative mood regulation to treatment outcome in a two-phase approach.

The first phase was focused on stabilization and preparatory skill building. Cloitre et al. (2004) concluded, through hierarchical regression analyses that “the strength of the therapeutic alliance established early in treatment reliably predicted improvement in PTSD symptoms at posttreatment” (p. 411).

Studies on the therapeutic relationship typically explore several factors. These factors include the type of treatment, the treatment length, early versus late alliance development, and individual client and therapist characteristics as measured against the outcome of a particular treatment approach (Horvath & Luborsky, 1993).

However, the participants’ reports hinted at the potential reparative effect of the therapeutic relationship itself. Traumatized children and youth have often also had traumatic relationships with caregivers. With other children, post-trauma ineptitude by caregivers (presumably unintentional) may play a role in whether an event reaches traumatic proportions or remains an upsetting and unfortunate circumstance in a child’s past.

The literature confirms that those with secure attachment histories are less likely to develop PTSD symptoms (Briere & Hodges, 2010) and a growing body of literature suggests that caregiver responsiveness in the immediate period following an overwhelming event can ameliorate or accentuate the effects of traumatic stress (Briere & Scott, 2006; Porges, 2003; Stein & Kendall, 2004; Teicher et al., 2010; van der Kolk & d’Andrea, 2010). Since the therapeutic relationship and its co-factor the therapeutic

container appear to have a significant reparative effect on trauma in children during the resourcing process, clinical efforts, and future research might target the best measures and approach for strengthening this alliance.

Children's resourcing experience deconstructed. The assessment of the data reported by the participants revealed a psychologically meaningful structure to their resourcing experience. It is important to clarify that a constituent differs from an element in that each constituent represents the essence of the experiences when taken together where an element would stand alone in representing a component of the structure. Twelve constituents were seen to comprise the structure of the resourcing experience for these children 1. perceived attitude of the therapist; 2. personal and contextual relevance; 3. currency; 4. choice and control; 5. calming; 6. unsticking; 7. experiential; 8. triumph; 9. internal ease; 10. needing a guide; 11. naming the resource; 12. betterment. The relative contributions of each constituent, to a better understanding of the resourcing experience from the point of view of the child-clients, are worthy of individual examination.

Perceived attitude of the therapist. Children and youth are sensitive to the perception that they are being judged. This perceived judgment could occur locally, such as from parents and family, but also more broadly from peer groups, community, and society. Participants in this study reported positive feelings and an increased receptivity to the resourcing experience associated with a non-judgmental therapeutic environment.

Young people wrestle with a plethora of external factors, which shape their identities and interact with their efforts at individuation. With their identities still being formed

during phases of growth and development, they are likely to internalize the input from those in their immediate and extended environments (Erikson, 1968). Such influences help them learn about accepted limits, boundaries, and behavior.

Children are exposed to a lack of attention, as well as distorted attention involving inappropriate emotions and physical contact, when there has been abuse and neglect in their lives. Children can also experience derogatory and accusatory verbal attacks by caregivers, or others. Often children and youth, who are subjected to abuse or neglected by caregivers, take on some level of personal responsibility for these situations (Adler-Tapia & Settle, 2008; Feiring, et al., 2002; Deblinger, et al., 2006). A similar phenomenon may occur even with accidents or natural disasters (Tinker & Wilson, 1999).

Therapists need to work at countering transference and avoid being equated with adults who may have been a negative part of the children's lives. This study revealed that many of the participants were sensitive to subtle indicators of criticism. Therefore, clear explanations of expectations and goals in an atmosphere of non-judgment are important for working with this population, perhaps more so than for other populations. An approach that assumes the children are capable of exploration and learning during resourcing sessions is also crucial.

Children in this study also described the qualities of a therapist that they found to be most helpful. Therapists who projected that they were calm and comfortable seemed to put their clients at ease. Having a soft voice that conveyed genuine caring and an authenticity in their desire to help were also seen as important.

An authoritarian tone and content was unhelpful. Instead, the therapist gently asking questions about how things were going and then inviting the participants' input on what was most significant and helpful, were key in establishing and maintaining rapport.

Personal and contextual relevance. Participants expressed a need for the sessions to be for, and about, themselves. When therapists wandered to more distant or general theories, the participants consistently attempted to bring the focus back to themselves and their unique circumstances. If the therapists persisted in a general or theoretical approach, the child-clients tended to lose attention and interest. They then viewed the therapist as either not understanding them or pushing an irrelevant agenda.

As children grow in their ability to employ abstract thought, they become more adept at generalizing from one situation to another. Traumatic experiences can create a pervasive atmosphere akin to a time warp where the past constantly informs and often dominates the present via this process of generalization. Some children experience perceptual flashbacks, others a triggering of the reaction to the trauma, evoked by the present circumstance.

Janet (1924) suggested that traumatized people narrow their field of perception to limit the amount of information they have to deal with. Interestingly, neuroscientists may offer a perspective on this phenomenon. They propose that the neocortex (the thinking, rationalizing, logical part of the brain) shuts down as the person's survival defenses (flight, fight, and freeze) take over when a triggering event transports the individual back to the trauma (Brewin, 2005; De Bellis, 2010; Porges, 2003).

This narrowing of focus during a triggering event, elicits the trauma in all its detail once more. For the traumatized person, time can remain anchored to the moments of the overwhelming event (De Bellis, et al., 2005). The details of traumatic incidents are often evoked by reminders, which may trigger the individual on a conscious or unconscious level (Scaer, 2001). Since traumatic events bring attention to details, a great deal of care and attention to detail is required for the resourcing to be an effective counter to the traumatic experience.

Psychoeducation. One result of this project is that I have had to reconsider my thoughts on psychoeducation. Psychoeducation for knowledge alone was reported as not being of much help by a number of the participants.

Merleau-Ponty pointed to a qualitative difference between having knowledge and embodying knowledge, which he referred to as embodied cognition (Hass, 2008). For some of these participants, having the knowledge did not translate into applying the knowledge or behavior. Applying the knowledge or behavior was sometimes described as *trying on* something new.

Participants often conveyed that the information provided by the therapists was excessive or irrelevant to their experience. When irrelevant, they often stated that the therapist had an agenda that was at odds with the participants' goals.

The descriptions of more effective psychoeducation revealed that information that was delivered either concurrent to the experience (for example, during an exercise), in response to a question posed by the participant, or following the experience was better received.

Currency. Giorgi and Giorgi (2003), emphasized that although their method was intended for psychologically sensitive inquiries, the jargon of the discipline should be avoided. They recommended instead the creative use of the language and therefore my choice of the word ‘currency’ for this constituent is an attempt to follow that advice.

Currency is used to incorporate both an orientation to the present moment as well as value for one’s effort and has multiple meanings in the context of the resourcing experience. I use the word here to refer to (a) meeting the clients where they are at with their pre-existing resources, (b) focusing existing resources on present day stresses, (c) doing so economically, and (d) doing so during the session rather than assigning practice as homework.

As was examined in the discussion on client focus, the participants seemed to find it important that a therapist resist the temptation to direct resourcing efforts immediately to what the therapist may believe is needed to concretely counter the trauma and in fact indicated that this was counter-productive. For example, even such an activity as getting back into the car after an accident that led to the death of a family member, may be perceived by the child-client as the forcing of the therapist’s agenda.

This can be unhelpful for the client, who may feel that they need assistance with something more immediate, such as the recent and difficult break up of a romantic relationship. The concept of currency encourages the therapist to attend to the recent stressor or loss, as resources useful for one kind of loss or stress may be transferable to those more remote in time.

Similarly, efforts at stabilization may be better directed toward daily functioning rather than focusing on resources directly related to prior traumatic events. The concept of currency, as revealed by the participants, also suggested that resourcing efforts, with the exception of those that assist with the stabilization of physically distressing states of hyperarousal, would best be negotiated with the client and collaboratively determined early in the session to ensure that they remain relevant and current.

Choice and control. A recurrent constituent expressed by the participants was that of choice and control. Trauma frequently undermines choice and control, which are important for the developmental task of individuation (i.e., the child's development of a sense of self as an individual stabilized personality; Erikson, 1963).

A search of the literature on individuation among adolescents in therapy failed to find studies, which directly addressed the relationship between adolescents' choice, sense of control or decision-making, and therapeutic outcomes. Neither was there research on the influence of therapy on the process of separation-individuation.

There is research, however, that indicates that factors such as secure attachment and authoritative parenting styles have strong correlations with successful individuation (Kruse & Walper, 2008). I agree with Shirk (1999) that therapists become proxies for family caregivers and other adult figures in the child/adolescent's circle of adult influences during the developmental process. The fact that the clients repeatedly, throughout the interview process, revisited the constituent of choice and control, underscores the importance of therapists being attentive to the particular attachment,

developmental and parenting style issues that may be relevant for their clients, especially as they relate to the therapeutic relationship.

Choice and control in the decision-making process of children has been investigated in recent years (Byrnes, 2002; Mann, Harmoni, & Power, 1989); however, choice was considered from the perspective of whether adolescents made “good” choices or “bad” ones. Competence in decision-making was related to the quality of the choices the adolescents made.

Children and youth are often automatically denied choice due to their ages. Sometimes, the child may select the best option available at the time, yet be left with the sense of having made an inadequate or incorrect choice under duress and in difficult circumstances. The loss of choice and control can be an opportunity for a corrective experience between client and therapist.

Calming. Participants positively commented on feelings of relaxation in the therapeutic environment and correlated them with a successful resourcing session. Traumatic experience triggers the child’s physiological state of increased arousal (DeBellis et al., 2005). The encouragement of calm, relaxed, and mellow states during resourcing sessions can be a means to down-regulate this arousal.

A state of calm can characterize both the sense of immediate relief, as well as the deeper sense of sustained ease following the experience of the resourcing session. The realization that there is a lessening of the traumatic re-experience can give rise to a sense of calm or even of joy as the child embraces a perception of triumph and the confidence that comes with mastery.

From a neuropsychological perspective, van der Kolk (2005) suggested that achieving a relaxed state in proximity to the traumatic event (e.g., such as by evoking memories of the trauma and mindfully discussing them) allows for the rational part of the brain, the prefrontal cortex, to remain engaged. This permits the child's attention to remain focused in the here and now and on realistic problem solving, rather than being hijacked by the re-experiencing of a flight, fight, or in children, a fidget response, associated with the trauma (van der Kolk, 2005). Openness, curiosity and new learning can more easily take place in this state (Ogden et al., 2007), creating the opportunity for trauma to be re-framed as well as for successful resourcing.

Unsticking. In addition to reporting positive feelings of relaxation in the therapeutic environment, some participants reported experiences that represented a sense of becoming unstuck. Calm, relaxed, or mellow states not only reduce the stress load on the client's nervous system, they also reduce the influence of the traumatic material on the degree of emotional distress felt by the child. This permits the child to potentially become unstuck (Janet, 1924) and move beyond the habitual, patterned and state-dependent responses of the traumatic activation (i.e., flight, fight, or fidget survival-based defensive responses; Ogden et al., 2006).

Once the traumatic material has been moved aside or moved to the background, the child can begin to explore other ways of being. The child may be more open to the resourcing component of therapy as he or she ceases to view him or herself as a traumatized survivor. This implies that, once more, therapists can encourage a very relaxed atmosphere with their own demeanor and attitudes as well as with a calming

ambience to the therapeutic container, which will support the receptivity of the client to the resourcing experience.

Experiential and embodied. Participants whose sessions included sensorimotor (a technique which involves an embodied awareness of present moment experience; Ogden et al., 2007), or bilateral stimulation (an EMDR technique that alternately stimulates each hemisphere of the brain such as therapeutic eye movement; Shapiro, 2001) appeared to gain an awareness of their own abilities, while participants who did not experience these techniques reported that the resourcing session had a less notable impact. Giorgi (2009) refers to this as an example of partial fulfillment of the invariant constituent and found such occurrences to be valuable in discerning what is and what isn't a constituent of the phenomenon. This latter group described some improvements in knowledge and understanding, and felt better after talking to someone who seemed to care about them. Although these observations do not translate into a statement of treatment efficacy, it does appear that these experiential constituents point to a crucial difference between those who "got it" and those who reported less helpful sessions.

I consider the experiential and embodied constituent, along with the triumph constituent, to be the nexus of the basic structure of the youth resourcing experience. In the experiential and embodied constituent, the therapist guides the child in the discovery of an alternative response to something that is troubling him or her. This response is customized to the client's particular needs and creates a healing therapeutic experience. By focusing on the felt-sense during the therapeutic encounter (often using mindfulness, a technique that encourages a constantly renewed focus on the present moment) the healing aspects of the resourcing experience is strengthened.

Sometimes, the therapist may use particular strategies and techniques to anchor the new way of being in the client's body. In this way the new knowledge also becomes a sensorimotor experience. In other cases, the use of bilateral stimulation while the client attends to images, thoughts and emotions, enhances the vividness of the experience. These two approaches promote a "trying on" of the resourcing experience. More cognitive, less experiential, approaches with participants appeared to garner mixed results.

Odgen, Pain, and Fisher (2006) wrote:

If traumatic memories largely consist of reactivated nonverbal implicit-type memories and habitual procedural responses with limited explicit memory components, then such memories may not be transformed adequately by insight alone (Grigsby & Stevens, 2000; Siegel, 1999; Sykes, 2004). We propose that sensorimotor interventions that directly address the body can work to process implicit-type memories, challenge procedural learning and help to regulate dysregulated autonomic arousal. (p. 299)

Though these authors directed their comment toward the processing of traumatic memories, it is reasonable to think that the same would apply to the resourcing process, since resourcing also challenges procedural learning and helps regulate autonomic nervous system arousal. Further investigation on this point seems warranted.

Triumph. Many participants reported that they experienced a pivotal moment of triumphant awareness, or change, in their sessions, after which the remainder of the resourcing experience made more sense and was powerfully incorporated as useful. This

constituent brings to mind the ‘eureka’ moment or the ‘ah-ha’ moment of the resourcing session; Lenore Terr (2008) refers to these moments as the magical moments of therapy.

During these moments, the calm and “chill” feelings of earlier in the session turn into positive feelings of accomplishment and joy. Janet (1924, p. 296) described the completion (i.e., “physically, socially, psychologically finished”) of appropriate action(s) as “acts of triumph” and theorized that the “discovery of pleasure” was important for stabilization and recovery. In that volume, Janet promoted his methods of education and the practices of body awareness and integrated physical action. He stated that “...it is not a question of fortifying the nervous and mental activity, of creating new resources, it is simply a question of making use of resources that the subject already possesses” (p. 259). Janet’s ideas offer a relevant explanation of what might have happened for the participants in this study.

It was often seen that once the participant reached such a moment in the resourcing experience, there was no turning back. A change had occurred and it was a breakthrough that invited further exploration. Such moments represent key opportunities for the therapist to acknowledge the accomplishment, the courage it took to make the change, and the positive feelings and sensations related to the triumph, such as the positive shift in self-regard.

Internal ease. Once a participant reported that the triumphant shift in perspective had occurred, they frequently expressed surprise at how easy the shift had seemed. They reported that resourcing happened at a level other than a superficial one: *It wasn’t just*

like I went oh, I just need to think differently about this. I felt different all over and way inside.

Perhaps it was the immediately transformative nature of the experience that left such an impression. There was a sense that the transformation had occurred beneath the child's usual defenses, or, as a few participants described it, there was a feeling or sense deep inside them that they had changed something of great importance. This constituent had a distinctly reflective quality. Moving into the last third of the therapeutic session, it is often the right time for therapists to recap and pay attention to the child's newly evoked way of being in the world.

Needing a guide. Many participants reported that they now understood that how they got to this new way of being was under their own control, through their own choices, which were made at key decision or choice points in the resourcing process. From here, the hope is that the child can regain confidence in his or her adaptive abilities and see that change is always possible.

A sense of freedom often arises from the knowledge that participants do not have to remain stuck forever, no matter what the past traumas. I think of this as the return to hope, in the same way as Erikson (1963, 1968) did when he first introduced this concept as a virtue acquired through the successful navigation of the Trust vs. Mistrust stage of development.

One finding that emerged seemingly pointed to a paradox: On the one hand, the participants' worked things out for themselves, from the inside. On the other hand, they readily acknowledged that the shift would not have happened without the therapist to

guide them. This apparent paradox signals the beginning of the understanding, through direct experience, that there is interdependence among people that can be a positive influence for choice and change.

It further assists in removing the isolative, fearful, and lonely characteristics often seen in a trauma survivor when the child comes to his or her own realization that a guide is needed. Supporting the child as he or she arrives at this conclusion assists in clearing the way for the therapeutic relationship to adaptively guide the child through the remainder of the resourcing component of therapy.

Naming the resource. Participants reported that the naming of the resource revealed during the session, seemed to serve as an important part of the integration of the resource. Also of significance was a discussion of the details of the resource: Is it new or is it something old but renewed?

Further exploration of how clients might be able to take the resource and their new perspectives, out of the office with them and put it into practice in daily life was an important point of discussion. By striving to help clients to understand that they carry the embodied state or felt-sense of the resource with them now, therapists may assist clients to be able to employ the resource when under stress and at times when they are feeling vulnerable. If clients can be encouraged to generalize in order to find similar resources in other situations, then they have learned an invaluable lifelong skill for getting their needs met, staying safe, and problem solving when under duress.

Betterment. As a trauma therapist, I have often reflected upon the contribution of resourcing to the tri-phasic approach to trauma treatment. Knowledge gleaned from the

participants has provided information on that issue. All participants were asked the question “If, when you started your resourcing session(s), the upset or disturbance about the whole issue you worked on was rated at 10/10, what would you rate it now - two weeks, three weeks, four weeks or five weeks - after your session?” For those participants who positively described the resourcing experience, the ratings given were typically between two to four out of 10.

Although this is obviously a subjective measure, it does appear that the sessions were of some positive significance to the participants. It is possible that any sense of disturbance that remains, represents the recalcitrant remnants of traumatic material that need further processing to resolve. I especially liked the word used by one of the participants, betterment. That resourcing is not resolution, but betterment is definitely a step toward stabilization.

Exploring “I don’t know...but”. As a horizontal feature and not a constituent of the resourcing experience, the additional data provided by this statement was quite valuable. I listened to the audio-taped interviews in their entirety, and then again during the transcription stage of data analysis. I noticed an interesting and frequent pattern to the responses of the participants to my interview questions. When I asked a question such as “How did you know that was the right thing for you?” or “What told you (such and such) was a good thing?” or “How did you make that choice?” the response was often prefaced with, “I don’t know, but ...” Upon further investigation it seemed that there was a great deal behind both the “I don’t know” and the “but.”

“I don’t know” seemed related to a lack of sufficient vocabulary to describe the sensate and emotional reactions to the question. Intrigued, I consulted the literature but found very little information that would help me to address this finding. However, Merleau-Ponty (1962) writes in *Phenomenology of Perception* “...secondary attention, which would be limited to recalling knowledge already gained... To pay attention is not merely further to elucidate pre-existing data, it is to bring about a new articulation of them...” (p. 35).

These comments are instructive. Although the participants may not have had an exact equivalent experience with which they could associate their resourcing experience, they, in Merleau-Ponty’s language, created a “new region in their total world” and were better able to attempt to articulate the novel experience. This becomes a “knowledge-bringing event” as the resourcing experience is brought to light through directed attention (i.e., by my asking of a question such as “How did you know that was the right thing for you?”).

In a later chapter Merleau-Ponty (1962) writes:

People can speak to us only in a language which we already understand, each word of a difficult text awakens in us thoughts which were ours beforehand, but these meanings sometimes combine to form new thought which recasts them all, and we are transported to the heart of the matter, we find the source. (p. 207)

Participants often struggled to articulate embodied knowledge. The language they already had was insufficient. Slowly, by associating known words with emerging thoughts, they were able to express their resourcing experiences more completely.

Some participants reported that they knew an experience was right, or that they could trust the experience, because, to quote “[I knew it] *in my being, in my body* or *because it was just obvious in all of me.*” When asked to elaborate further, these participants found it difficult to articulate their felt experience, saying they didn’t really know how to describe it, yet they were adamant that they knew what they meant. As suggested by Merleau-Ponty, this ineffable knowledge described by the participants is that of embodied cognition.

Several other philosophers including Kant and Heidegger, as well as cognitive scientists such as Damasio and Ramachandran have also advanced theories of embodied knowledge, from various different perspectives. The shared fundamental postulate was that, below the level of intellectual judgments exists a “pre-positing embodied-conscious life” (Hass, 2008, p. 89).

I surmise that it was from this pre-cognitive level that these participants were trying to answer my questions. By paying attention to this, I was able to deepen my understanding of their experiences. It is also possible that through this exchange, the participants were discovering even more about the impact of their resourcing experiences. As one participant stated ...*this is such a hard question...but it is like that is how I know things...I know them with my whole being...that is amazing...wow, I am not so dumb as I thought.*

For therapists who work with younger client populations, pursuing, “I don’t know, but...” could be a very powerful point of exploration, learning, and growth. For

resourcing, it could be a helpful viewpoint to have and draw upon as trauma processing gets under way.

Phenomenology and Knowledge by Acquaintance in Child and Youth Therapy

I found the phenomenological approach to be a valuable way of building rapport with the participants. Additionally, the approach made it relatively easy for me to gain an understanding of how the children made sense of their experiences, and place me vicariously close to their experience. I believe that clients can benefit from the extension of client-centered approaches to include a phenomenological perspective.

Therapists may be better positioned to offer meaningful, case-specific interventions, as they collaborate with children and youth, if they can relate to the client's distress through *knowledge by acquaintance* (first-person knowledge obtained via one's intuition). By incorporating Janet's (1924) ideas on strengthening resources that already exist, every client can be seen as having the potential for healing.

Once stabilization has occurred, through focusing on present-day challenges, and after trauma-related stress and physiological arousal have settled, the way is paved to work with any remaining traumatic material. The phenomenological approach seems well suited as a form of therapy that goes from present to past, from immediate issues to remote ones, and from those that the child identifies as important, to those that may be hidden under layers of fear, shame, and hopelessness.

The sentiment of several participants conveyed in the phrase *doing, not thinking*, offers a potential shift in the therapeutic approach to resourcing with children and youth in trauma therapy. The participants' responses indicate that direct experience needs to be

a primary focus in therapeutic resourcing. This is not to suggest that thinking is of no value, rather, that the thinking-through or cognitive component of the resourcing experience should be encouraged only in support of the direct experience.

This approach contrasts with purely cognitive techniques where the child would be encouraged to intellectually “try to figure it out”. Working through the experience and understanding change experientially, seems to offer benefits that are different from other, more cognitive approaches, and can offer additional insight and healing.

Evaluation of the Conceptual Framework – An Experiential Summary

A conceptual framework was formulated after a thorough and comprehensive literature review, during which time I established the “working categories” of (a) language; (b) role; (c) activities; (d) meaning; (e) therapeutic implications (Appendix E). I anticipated that this method of data collection would yield a substantial amount of evocative, descriptive text that would require organization into manageable and meaningful categories (Giorgi, 1997).

Data collection began with this data analysis in mind. I had anticipated that the constituents might roughly resemble those of the conceptual framework. Although the framework’s categories were embedded in the results of the analysis, the categories did not match how the participants described the meaning of the resourcing experience. Attempting to fit the results into the framework’s categories would have betrayed the voice of the participants and abandoned the phenomenological psychological attitude.

Giorgi (2006) asserted that the phenomenological attitude, when properly employed, results in eidetic findings, and I wanted to remain loyal to the participants’ experience.

However, I acknowledge that I was clarifying the child/youth experience of resourcing for the sake of the discipline and not merely for the sake of the clients.

I anticipated organizing data through a process of reading and re-reading in order to initially gain a “feel” for the overall experience (Giorgi, 1997). Next, by looking for the essential constituents that represented the essence of resourcing, I sought minor and major themes (Danaher & Briod, 2005; Gall et al., 1996; Hennessy & Heary, 2005). This sequence did not proceed as I had anticipated.

As I immersed myself in the data, I realized that there were significant and sometimes conflicting concepts and instructions if I were to use either a descriptive, empirical, or existential method. I had the difficult decision of determining which approach would be most suitable for my research question.

I also looked at what would provide me with the most usable information, since I wanted the results to assist trauma therapists who work with children and youth. Finally, I focused my analysis on Giorgi’s (1997) descriptive phenomenological psychological method as being the most suitable methodology and the one most likely to allow for the insights that I had hoped for. However, the final chapter includes an attempt at explication and clarification that I must concede as a departure from Giorgi’s (2009) method. I did try to remain as close as possible to the concrete descriptions of the participants in my effort to make the findings relevant for trauma therapists.

Husserl’s mantra “back to the things themselves” (Hass, 2008) provided me with focus during the times when I was tempted to wander too far off into related areas of resourcing (e.g., the horizontal features). Overall, I engaged in a process of looking at the whole as

well as the parts, as a picture of resourcing from the perspective of the participants began to emerge.

Todres and Holloway (2004) suggested that the final “digested” synthesis of any study necessitates two concerns. The first, the scientific concern, is focused on the phenomenon and the research participants’ experiences. The second, the communicative concern, attends to the readers of the research document and the purposes to which the research findings may be used. I have tried to keep these two concerns foremost in my mind throughout the inquiry.

The development of the conceptual framework was helpful in and of itself to organize the available literature in a way that I had not done previously. This also helped me set aside that body of knowledge, to allow the current findings and constituents to come fully forward.

It is my hope that the categories of the conceptual framework may in fact be helpful for orienting future research projects. When combined with the findings and constituents that emerged from this project, the path has been paved for future research endeavors.

The Path of Most Resistance - Research Down the Roads Not Taken

I found the exploration of the resourcing experience with the young people who participated in my study to be a very rewarding and enlightening process. It re-affirmed my belief in children and youth as reliable informants for qualitative approaches. I enjoyed the opportunity to explore their experiences and found the particulars and depth of their accounts to be satisfying and inspiring. As a first step in the research of

children's experience of resourcing in tri-phasic trauma therapy, this inquiry offers many launching points for both qualitative and quantitative directions in future studies.

Giorgi (2006) advised "it is quite possible that terms not found in the transformed meaning units are required to describe the structure" (p.253). Here Giorgi concedes that descriptive phenomenology is never finished, but instead is an ongoing and ever expanding understanding of empirical data.

This study revealed 12 essential constituents of the basic structure of the youth resourcing experience. There are likely to be more and there may be variations of the 12 found here. Further, the implications that have emerged from this study, for practicing therapists resourcing with children in individualized tri-phasic trauma therapy, are summarized for convenience in Appendix K and each may be deserving of additional investigation.

The descriptive phenomenological psychological method proposes a modest level of generalizability and does not seek universal application (Giorgi and Giorgi, 2003). However, the participants' descriptions do indicate several directions for further research. One is the role of perceived judgment or criticism in the therapeutic relationship. Another might explore more collaborative approaches with children and youth during the resourcing component of trauma therapy.

Quantitatively, the identification of variables in the resourcing process (e.g., mediators, predictors, correlations) may expand our understanding and improve our resourcing efforts. An operationalized definition of resourcing remains a problem for future quantitative research that may also be addressed.

In conclusion, it is the nature of history that those that are choice-less are finally able to choose and that those who are voiceless are finally heard. Children who have undergone trauma have had many of their choices taken away from them. It is incumbent on researchers and therapists alike to, not only give them back the sense of control that comes with the ability to choose, but to give voice to them as the true experts of their own experience.

As Max Lerner (1950) said in *The Unfinished Country*, his collection of daily columns written for the *New York Post*, “The turning point in the process of growing up is when you discover the core of strength within you that survives all hurt.” It is my hope that this study will be the beginning of that very turning point for researchers, therapists and most importantly, for children.

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Appendix A: Glossary

Affect Regulation. To control, adjust, or direct emotion. The ability and adeptness for affect regulation is related to early experiences with caregivers. It is associated with physiological arousal in that emotion influences the autonomic nervous system.

Arousal Modulation. Arousal refers to the physiological state of alertness experienced by the person. Modulation of arousal relates to both the person's unconscious and conscious efforts to control, adjust, or harmonize his alertness. Unconscious efforts are a result of feedback loops in the autonomic nervous system, namely the sympathetic and parasympathetic systems. Conscious efforts are related to a degree of mindfulness (attention on the present moment) and self or other interventions or the direct employment of techniques, such as relaxation exercises, thought refocusing, etc.

Cognitive restructuring. Albert Ellis (2003) and Aron Beck (Newman, 2003) pioneered cognitive restructuring as a strategy, which challenges faulty thinking with the hope of countering negative ideas about oneself and the world.

Development. In its broadest sense, development means growth. When applied to human development it refers to the process of growing to maturity: from a one-celled zygote to an adult human being. Typically it is referred to in terms of age-related stages, each having one or more sub-categories: Prenatal (fertilization-birth); Child (0-19); Younger adult (20-39); Middle-aged adult (40-59); Advanced adult (60+). Human development is often broken into two categories: Developmental Biology and Developmental Psychology (sometimes also referred to as psycho-social development).

Developmental Psychology is a broad field and may refer to anthropological, sociological, and psychological aspects of human development in context.

Development can be seen as a sub-category of the Evolution paradigm, which originated as a biological theory and now includes branches of Evolutionary Psychology and Evolutionary Developmental Psychology.

Developmental Needs. An economic term, it can be viewed as something required or necessary for growth. A developmental need could be related to people themselves, another person or a group of people, a situation, a circumstance, an event or a relationship. Developmental needs provide the motivational energy for action. Widely associated with Maslow's hierarchy of needs, which includes the following categories: physiological, safety, love/belonging, esteem, and self-actualization.

Post-traumatic stress. Stress resulting from trauma. May be viewed as a subjective phenomenon. Conceptualized on a continuum from mild to severe. The most severe being in the realm of the diagnostic categories Adjustment Disorder, Acute Stress Disorder, and Post-traumatic Stress Disorder (PTSD).

Psycho-education. Refers to the education offered to people who live with a psychological disturbance. The goal is for patients to understand and be better able to deal with their presented illnesses. Also, patients' own strengths, resources and coping skills are reinforced, in order to avoid relapse and contribute to their own health and wellness on a long-term basis. The theory is, that with better knowledge of their illnesses, the better those patients can live with their conditions.

Resources. Personal skills, abilities, traits, relationships, objects, services, and experiences that facilitate self-regulation and provide a sense of competence, connection to self, others and the environment, as well as a sense of resilience (adapted from Ogden et al., 2007).

Resource Development or Resourcing. The development, creation, reinstatement or embellishment of resources with the intention of assisting positive growth and psychological outcomes in the context of therapy, especially trauma therapy.

Safe place technique. The safe place technique is used by clinicians as a calming measure, to provide a positive contrast to the painful re-experiencing, in the present, of past trauma. Sometimes called the calm or comfortable place, the therapist guides the person to notice information provided by all five senses as they explore a real or imagined place.

Skills-based Intervention. Arising from the behavioural approach, coping skills training, social skills training, stress inoculation training, relaxation techniques training, competence building, and capacity building form the common skills-based interventions. These differing techniques have similar goals: to increase available methods or strategies should the person experience or re-experience trauma.

Stress. Emotional pressure.

Stressor. Environmental condition or influence that causes stress for a person. May be internal or external to the person.

Trauma. Typically divided into two categories: Physical trauma and psychological trauma. Physical trauma refers to blunt force (caused by impact with a blunt object) or penetrating (physical injury that breaks the skin); or body-altering physical injury such as bruising, piercing, dismembering, or severing of the body or body parts. Psychological trauma refers to an emotional or psychological injury that usually results from extremely stressful or life-threatening events, circumstances, situations, or relationships. The word trauma originates from the Greek word for “wound.”

Appendix B: Common Therapeutic Approaches to Trauma Treatment

Exposure. Therapeutic exposure has been described as “repeated or extended exposure, either in vivo or in imagination, to objectively harmless, but feared stimuli for the purpose of reducing anxiety” (Abueg & Fairbank, 1992, p. 127). From the trauma perspective, the “objectively harmless” stimuli are memories of prior trauma that are, by definition not currently occurring; the “anxiety” is the triggered emotional response to these trauma memories. Foa & Rothbaum, (1998) demonstrated the effectiveness of “prolonged exposure therapy” for treating adults with sexual assault trauma. Most exposure therapies are variants of Wolpe’s (1958) systematic desensitization, which asks the person to recall non-overwhelming, yet moderately distressing, traumatic experiences in the context of a safe therapeutic environment.

Cognitive Behavioral Therapy. CBT is a psychotherapy based on modifying cognitions, assumptions, beliefs and behaviors, with the aim of influencing disturbed emotions. The general approach developed out of Behavior Modification, Cognitive Therapy and Rational Emotive Behavior Therapy. The particular therapeutic techniques vary according to the particular type of client or issue, but commonly include keeping a diary of significant events and associated feelings, thoughts and behaviors; questioning and testing cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation and distraction techniques are also commonly included. CBT is widely accepted as evidence and empirically based, cost-effective psychotherapy for many disorders and psychological problems.

Eye movement desensitization and reprocessing. Eight phase psychotherapy developed specifically with a trauma population, EMDR supposes that traumatic material is stored in maladaptive memory networks isolated from the usual adaptive information processing. The traumatic material is accessed and reprocessed from cognitive, emotional and physical perspectives while engaging the person's innate adaptive information processing abilities. EMDR has endured a controversial evolution as psychotherapy since it integrates many aspects resembling exposure and cognitive-behavioral approaches and only recently investigated the use of eye movements during active treatment phases.

Art, Play and Expressive Therapies. Expressive therapy, also known as creative arts therapy, is the intentional use of the creative arts as a form of therapy. Unlike traditional art expression, the process of creation is emphasized rather than the final aesthetic product. Expressive therapy works under the assumption that, through use of imagination and the various forms of creative expression, humans can heal. Most forms of creative expression have an equivalent therapeutic discipline: art, dance, drama (psychodrama), music, play (including sand tray), writing (includes poetry and bibliotherapy), and humor.

Developmental Needs Meeting Strategy. The DNMS is another integrative approach more interested in the repair of developmental wounds and related trauma such as chronic neglect and abuse, as well as attachment wounds. It is included here since it is one of the few therapies, which include a resourcing component in the treatment program. The DNMS employs an ego-state model and sets out a protocol to establish a set of resources in the form of positive parts of self that are used to help process

attachment, developmental wounds and trauma. The resourcing phase of this approach seeks to exemplify and amplify the existing skills and traits of the person and uses these to revisit the origins of present day symptoms and distress.

Body-oriented/Somatic. The body-oriented approaches are seeing a resurgence of interest in the clinical community. Most often these approaches go beyond using the body as an access route to traumatic experience and memory by integrating thoughts, feelings, sensation, sensory perception, and movement into the person's awareness. This review uses Sensorimotor Psychotherapy as the exemplar of the body-centered approaches but acknowledges that each approach may differ in practice despite having common principles.

Appendix C: Human Ethics Review Board Certificate



University
of Victoria

Human Research Ethics Board
Office of Research Services
Administrative Services Building
PO Box 1700 STN CSC
Victoria British Columbia V8W 2Y2 Canada
Tel 250-472-4545, Fax 250-721-8960
Email ethics@uvic.ca Web www.research.uvic.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR: Rochelle Sharpe Lohrasbe UVic STATUS: Ph.D. Student UVic DEPARTMENT: CHIL SUPERVISOR: Sibylle Artz	ETHICS PROTOCOL NUMBER: 10-300 ORIGINAL APPROVAL DATE: 17-Aug-10 APPROVED ON: 17-Aug-10 APPROVAL EXPIRY DATE: 16-Aug-11
PROJECT TITLE: Traumatized Children's Experiences of Resourcing RESEARCH TEAM MEMBERS: None DECLARED PROJECT FUNDING: None	
CONDITIONS OF APPROVAL	
<p>This Certificate of Approval is valid for the above term provided there is no change in the protocol.</p> <p>Modifications To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.</p> <p>Renewals Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.</p> <p>Project Closures When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.</p>	
Certification	
<p style="text-align: center;">This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.</p> <div style="text-align: center; margin-top: 20px;"> <hr style="width: 20%; margin: 0 auto;"/> <p>Dr. Afzal Suleman Associate Vice-President, Research</p> </div>	

10-300 Rochelle Sharpe Lohrasbe

Certificate Issued On: 17-Aug-10

Appendix D: Demographic Questionnaire

Name: _____

Age: _____

Grade: _____

In conversational style:

Where do you go to school?

Invitation to tell me how you like school.

Friends, Family

Places of travel, other funs things? Sports?

Pseudonym:

Appendix E: Conceptual Framework

The process of the review and critique of literature relating to resourcing children with traumatic experience, along with the researcher's own experience and insights, has led to the development of a conceptual framework for the methodology and methods of the proposed study. The framework is intended to help focus and shape the research process, inform the design, and assist with the identification of appropriate data-collection methods for the study.

Following data collection, the conceptual framework will provide preliminary categorical vestibules for data sorting and coding. Therefore, this framework provides an organizational structure for reporting the study's findings, in addition to supporting the analysis, interpretation, and synthesis of these findings in the fashion of a *working tool*.

Each of the following questions provides the basis for the categories of the conceptual framework:

1. What do children have to say about their resourcing experience?
2. How do children experience resource development and resourcing activities?
3. What meaning do children attach to their resourcing experience?
4. How might children's perceptions of the resource development experience inform the practice of resourcing?

The first question hopes to capture the language of resourcing from the child's perspective and further seeks to understand the role of resourcing in the children's lives in general and in their therapy specifically. The second question intends to explore their

experience of the details of resourcing: How was it introduced, what activities did they experience as resourcing, and how do they now embody resourcing? Question three probes for relevance and meaning for the children. The fourth question seeks to tap into the child's wisdom in order to provide information, which may benefit other children's resource development. The first, second and to some extent the third questions focus on the child's internal experience, while the final question broadens the focus to others. The questions attempt to clarify resourcing language, role, activities, meaning, and therapeutic implications.

Language. The literature identifies multiple terms used to describe types of resources. The category of language seeks to identify the words, actions, or feelings used by the child participants to name resources.

Role. The literature review revealed a theoretical perspective on resourcing including its use for safety and stabilization, especially during the first of the phases in the tri-phasic approach to trauma therapy. Indications of corroboration in the children's experience will fall into this category.

Activities. Included here are the tasks and actions of the resourcing sessions, yet it is not the unique detail but rather the common experience or quality that is of interest. What happened during the session that was particularly notable with respect to resource development? The literature suggests such activities as psychoeducation and skills training, or completing truncated movements (for instance, defensive movements like pushing or blocking) are essential to the resourcing process.

Meaning. A significant aspect of the study's objectives is to elucidate and explore a deeper understanding of resourcing. The category of meaning is concerned with how the children integrate the experience of resourcing into their lives.

Therapeutic Implications. Therapeutic implications gleaned from the information provided by child participants will include aspects of resourcing which can be integrated into practice with other children. It is anticipated that this category may draw on information obtained from the previous categories.

Appendix F: Interview: Instructions and Questions

R: I am going to start the recording now, ok? *Slightly slower pace than conversational speed of speech:* Think about a time when you were at Name of Therapist's office when you experienced or felt or discovered something that helped you understand that you could do something or get past something that was upsetting or getting in your way. Maybe it was a skill, or something you were good at. Maybe it was something about yourself, or a part of you. Maybe it was realizing that someone was there for you. Maybe it was a tool or something like a hammer or a ladder or key that you figured out would be helpful. Or maybe it was a place you could go to get what you needed, like a community center or a hospital.

Does something like that come to mind for you? Would you be willing to tell me about it and would it be ok if I asked some questions?

Would it be okay with you if we started with you just telling me about your experience? I will write down what you say and then after maybe we could go through it together so that I can do my best to make sure that I really understand what it was like for you. Does that sound ok? I have some paper, markers and pencil crayons if you would like to draw anything about your experience and if it is ok with you, I might like to ask you some questions about anything you draw. Any way you want to express your experience is ok with me, even if a song comes to mind or you want to move or dance. It is up to you and it is all ok with me.

We can take a break anytime you would like? And, when we are finished you are welcome to select something from the Treasure Box.

How does that sound to you? (If fine and agrees, I will again read the focusing statement written above).

Potential prompts: It would be great if you could describe anything that comes up for you, that you remember, or thought or felt about the experience, either at the time or later or even just now as you are thinking about it. Maybe a picture or image may come up or a story.

Please tell me more about... *use the child's words*.

I am curious about when you said... *use the child's words*, could you say more about that?

What was it like for you to discover/learn *name the resource or quality of self*?

What does having had this experience mean to you?

Other questions are likely to begin with: How do you know...? What makes you think, feel ...?

What are the thoughts, feeling, physical sensations, movements, or 5-sense perceptions (images, sounds, touch, tastes, smells) that go with your experience?

Does it remind you of...?

Is there anyone you know that had a similar thing happen?

Are there stories or books that you think of when you...?

Are there movies or TV shows...?

Favourite character it reminds you of?

Would you wish for something like this to happen to someone you know? Who [not a name but the relationship]? Why?

Note: Any response might be followed up with something like, “How do you know that...?” or “What makes you think/believe/feel that way?” or “Could you tell me more about that?”

Appendix G: Participant Recruitment Infosheet for Therapists

Seeking Children to Participate in Research

WHO

- Children who are currently in therapy due to traumatic experience.
- Ideal participants will have had a recent experience of resource development.
- Participants must be willing to talk about their experience of resource development in the context of their therapy.

WHAT is Involved?

- Participants will be asked to discuss their experiences of resource development as part of their therapy.
- Two interviews, which will be tape recorded.

WHEN

- The interviews will be conducted individually at mutually agreeable times between the dates of Sep 1, 2010 and Nov 15, 2010.

PURPOSE

- The purpose of this qualitative research study is to explore resource development through the experience of children. Participants will be asked to talk about their experience of resource development as part of their therapy.

IMPORTANCE of this Research

- There is a lack of research, insight and knowledge about resource development and children's experience in therapy. No research addresses the needs, issues, desires, and experiences of these children.

Compensation: Participants will have the option to select an item from "The Treasure Box" (movie admission certificate, iTunes card. Value approx \$10)

For more information contact: Rochelle Sharpe Lohrasbe at rochelle@uvic.ca or 250-889-3469 Rochelle Sharpe Lohrasbe is a PhD student at the University of Victoria, in the department of Child and Youth Care. She has worked as a trauma therapist and educator. She is working under the supervision of Dr. Sibylle Artz (sartz@uvic.ca). **Participants' information is kept confidential and private.**

Appendix H: Participant Information

Hi. My name is Rochelle and I am working on a school project studying children's experiences of resourcing when working with their counsellor. Maybe recently you learned something about yourself, or discovered a skill you have or a person who is helpful to you that helped you get past something that was hard for you. Your counsellor might have called this a RESOURCE. A resource can be any skill or ability, or person or thing that helps you. It can be something inside you or it can be something from outside you. Do you think you could describe an experience of finding a resource?

Why this is important: I am interested in hearing about any experience you had while seeing your counsellor that might be a resourcing experience for you. The reason that I am interested is because most of the information for counsellors on resourcing is from adults. I think kid's experiences are important and it might help other kids and also the counsellors to understand more about this kind of experience. I also work with kids, who sometimes get stuck and need to learn about resources in order to help them get unstuck. But since I am not a kid, it is hard for me sometimes to guess at how to help someone.

What do you have to do if you participate? Meet with me at a time and place that is good for you. I will ask you to describe your experience and I will have questions that will help me understand correctly. We might spend about an hour together when we talk about your experience. Later on, I might need to ask a few more questions or make sure that I understand something you said correctly. That would mean we would meet again for probably a shorter time, maybe half an hour.

In my report I might use some of your descriptions of your resourcing experience but just like with your counsellor, anything else we talk about is not shared with anyone else. I will ask you to pick a secret name to keep things private.

It is possible that talking about your experience might remind you of things you don't want to think about. You do not have to talk about anything you don't want to. You can stop at any time and you can choose not to answer any question you don't want to. You can talk to your parents, your counsellor or to me if you need to.

You can call and talk to me directly if you want. Or, you can ask your mum or dad or caregiver to call me. My number is: 250.889.3469 or send me an email at rochelle@uvic.ca.

Thanks for considering taking part in my study of children's resourcing experiences.

Appendix I: Parent Information

Hi. My name is Rochelle and I am working on a doctorate in Child and Youth Care. I am studying children's experiences of resourcing when working with their counsellor. Resourcing happens when people learn something about themselves, like a skill or ability, or discover that a particular relationship is helpful to them getting past something very upsetting or traumatic. Your child's counsellor might call this a RESOURCE. A resource can be any skill or ability, or person or thing that helps you. It can be something inside you or it can be something from outside you.

Why this is important: I am interested in hearing about your child's resourcing experience. The reason that I am interested is because most of the resource development information available for counsellors is from adults. I think children's experiences are important and it might help other children and also the counsellors to understand more about this kind of experience. I also work with traumatized children, who sometimes get stuck and having this information would greatly inform my practice and improve my ability to help.

What does participation mean? I would meet with your child at a time and place that is good for you. I will ask your child to describe any experiences of resourcing. I may also ask questions that will help me understand accurately. The first interview is expected to take an hour and a possible follow up might take an additional 30 minutes. It is important to me that I understand your child's experience correctly.

I will explain consent and confidentiality to your child prior to beginning the interview. I will ask the children to select a pseudonym to protect their identities. In my report I might use some of the descriptions of resourcing experience. These would be in their exact words, but will not contain any identifying information.

Participation in the study is of low risk for harm. Typically, resourcing is a positive and empowering experience. It is possible that talking about the resourcing experience your child might be reminded of upsetting events or situation. All children will be assured that they are not required to talk about anything they do not want to and they can stop the interview at any time without repercussion. The children will be advised that should anything upsetting remain after the interview they can talk to parents/caregivers, their counsellor or to me if they like.

Please feel free to contact me should you have any questions. I can be reached at: 250.889.3469 or email at: rochelle@uvic.ca.

Thanks for supporting this valuable project.

Appendix J: Consent Form

My name is Rochelle Sharpe Lohrasbe (rochelle@uvic.ca), and I am a Doctor of Philosophy student at the University of Victoria, in the department of Child and Youth Care. I have worked as a counsellor for children and adults who have experienced trauma, and taught other counsellors who work in my area as well. I am presently working on my dissertation, a program requirement to complete my degree. The topic of my research is *Resourcing: Children's Experiences in Therapy*. I am working under the supervision of Dr. Sibylle Artz (sartz@uvic.ca).

Purpose and Objectives

The purpose of this qualitative research study is to explore resource development through the experience of children currently participating in therapy. Participants will be asked to talk about their resource development experience a part of their therapy.

Importance of this Research

There is a lack of research, insight, and knowledge about resource development and therapy with children. The majority of recent research has focused on adults and has not considered what resourcing is for children. It is important for children to have a voice and in turn this voice may help improve treatment for other children. This research will help counsellors and child and youth care professionals better understand the resourcing needs of children by helping them to understand what the resourcing experience is like, including the important aspects of resourcing.

Participant Selection

I am looking for children who are working with a therapist/counsellor because upsetting and overwhelming things have happened to them or involved them. Participants must be willing to talk about what it was like when they got to focus on resources that helped them or when they got to develop resources during a session with their therapist/counsellor.

What is Involved?

Participants will be asked to discuss the experiences of resource development. You will be asked to participate in one or two interviews that will be audiotaped. Your participation will begin with a discussion about the experience of working with your therapist/counsellor to identify strengths, abilities, and helpful or safe relationships. While we are talking about these positive experiences, I might ask you questions to help me understand what your experience was or how it was important or meaningful to you. Once your data has been collected and analyzed, a second interview may take place. At

the second interview you will be asked to clarify any of your responses. I anticipate the combined time to complete the two interviews will be between two to four hours, dependent on how much information and talking participants do.

The interviews will be conducted individually and will commence at mutually agreeable times between the dates of September 1, 2010 and November 15, 2010. The interviews will be conducted at one of several possible locations such as the University of Victoria in Victoria, British Columbia; a child-friendly therapist's office in Victoria, or at a location specified by the participant. Maps of the University of Victoria, directions to the room, and parking details are available upon request. Similar details for other locations are also available on request. Information from this study will be used in writing my dissertation, in scholarly publications, and at conference presentations. Copies of individual data results and/or all participants' data results are available upon request.

Inconvenience

Participation in this study may cause some inconvenience such as travel to and from the interview and the time for the interview.

Benefits

There are potential benefits for participating in this research. Participants will have the opportunity to share their experience and have it impact research. Participants will have the opportunity to reflect on their experiences, perhaps gaining a new perspective or self-reflection from the process. Participants will gain insight on their experiences and see the commonality of their experiences with other children.

This research has potential benefits to society. Knowledge and information emerging from this study can inform knowledge, theory, and practice in respect to children in therapy. This can assist in improving care and potentially the effectiveness and efficiency of therapeutic approaches.

To compensate participants for their time, each will have the option of selecting a prize (approximate value \$10) from "The Treasure Box" or choosing a movie ticket certificate at each interview.

Risks

There are potential risks to participants by participating in this research. These include possible emotional stress or discomfort from talking about stressful experiences. To prevent or deal with this risk, I have compiled the following list of agencies for participants to contact for support should they encounter emotional discomfort from the interviews:

Victoria Resources

Emergency Mental Health Services – accessed through NEED Crisis and Information Line NEED Crisis and Information Line	250-386-6323
Mental Health and Addiction	250-727-3544
Sooke Family Resource Society – Counselling Centre	250-642-5152
Victoria Family Violence Prevention Society	250-380-1955
Women’s Sexual Assault Centre	250-383-3232
Capital Mental Illness Information	250-389-1211
Mental Health Info Line	1-800-661-2121
Narcotics Anonymous	250-383-3553
Single Parent Resource Centre	250-385-1114
Women’s Transition House, Victoria	250-385-6611

Should participants experience distress at any time during the interviews, they can take a break, terminate the interview and resume the interview another time, or withdraw from the study. Any of this may be done without any risk or consequence.

Voluntary Participation

Participation in this research must be voluntary. Participants may refuse to participate or withdraw from the study at any time without repercussion. Participants have the right to refuse to discuss any aspect of their experience. If a participant decides to leave during the study, the audiotapes of this interview will be erased and any notes shredded, unless the participant gives consent to use the material already obtained.

Compensation

As a way to compensate you for any inconvenience related to your participation, you will be given a choice between selecting an item (worth approximately \$10) from “The Treasure Box” and receiving a movie ticket certificate for each interview. If you agree to participate in this study, this form of compensation to you must not be coercive. It is

unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation was not offered, then you should decline.

Anonymity

Individual interviews will be audiotaped. The audiotapes will be erased upon completion of the project by April 2011. The written text of the interviews will be kept for future conferences and papers. A pseudonym will be used in place of participant's real name. Only the researcher, Rochelle Sharpe Lohrasbe, will know the participants real identity. All information obtained will be kept confidential and interview results will be kept in a locked file cabinet.

Confidentiality

Confidentiality will be maintained throughout. Due to British Columbia law, there are a few situations where the researcher is lawfully bound to break confidentiality. These include hearing about a child or vulnerable person at risk for abuse, a participant at risk for suicide, or person at risk for harm or death. Should the need arise the researcher will protect participant identities as much as possible.

Participant confidentiality and the date will be protected by securing audiotapes, transcribed data, and consent forms in a locked filing cabinet in the researcher's home. Any data stored on computer will be password protected. This data will be destroyed after 5 years. Audiotapes will be destroyed 1 year after full transcriptions are made.

On-going Consent

To confirm your consent to participate in this research, I will ask participants to sign a consent form at the beginning of the first interview. I will remind you and ask for verbal consent at the beginning of the second interview and resign the original consent form.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: directly to participants, published articles, thesis, presentations at conferences or to the public, and scholarly meetings.

Disposal of Data

Tape recorded data from this study will be disposed of by January 2010. Paper copies of transcripts will be kept in a locked file at the researcher's home for future reference.

Contacts

Individuals that may be contacted regarding this study include the researcher, Rochelle Sharpe Lohrasbe, at rochelle@uvic.ca 250-889-3469 and research supervisor, Dr. Sibylle Artz at sartz@uvic.ca or 250-721-7211. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria at 250-472-4545 or ethics@uvic.ca .

I, the undersigned, give my permission to take part in the study described above, interview #1.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Participant's Name (please print): _____

Participants Signature: _____ Date: _____

I, the undersigned, give my permission to take part in the study described above for, interview #2.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Participant's Name (please print): _____

Participants Signature: _____ Date: _____

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix K:

Recommendations for Therapists - Resourcing in Children's Trauma Therapy

1. Children's focus shifts from the therapeutic relationship and container to the resourcing process after the first approximately 20 minutes of the therapy session, so this would be an ideal time to encourage and strengthen the therapeutic alliance. The therapeutic relationship itself seems to have reparative effects for children.
2. Children seemed to prefer that their resourcing worked on current difficulties in their lives rather than focusing on the traumatic material and that resourcing practice take place during the session rather than being assigned as homework. Similarly, efforts at stabilization may be better directed towards daily functioning.
3. Children reported positive feelings and an increased receptivity to the resourcing experience associated with a non-judgmental therapeutic environment where they received clear explanations of expectations and goals.
4. A therapeutic approach that assumes that children are capable of exploration and learning during resourcing sessions is helpful.
5. Therapists should use a calm and comfortable manner, a soft voice that conveys genuine caring and should communicate an authentic desire to help. Authoritarian tone and content is unhelpful.
6. Children preferred that the therapist gently ask questions about how things were going and invite the child's input on what was most significant and helpful.
7. Sessions should maintain a child-centered focus that acknowledges the child's unique circumstances as opposed to introducing general concepts or theories. Psychoeducation was contraindicated during the children's resourcing experience. It was considered by the children to be irrelevant and led them to conclude that the therapist had an agenda that was at odds with the children's own goals. Psychoeducation may better applied as questions are raised during sessions, or if misunderstandings or misinformation becomes apparent.
8. For child populations, a great deal of care and attention to detail is required for the resourcing to be an effective counter to the traumatic experience.
9. Resourcing efforts, with the exception of those that assist with the stabilization of physically distressing states of hyperarousal, would best be negotiated with the

child and collaboratively determined early in the session to ensure that they remain relevant and current.

10. A child's sense of the loss of choice and control resulting from a trauma would best be correctively and actively addressed with additional attention paid to the particular attachment issues and parenting styles that may be relevant for each child, as they pertain to the therapeutic relationship.
11. A calming and relaxed environment may encourage the child to relax and facilitate the process of becoming unstuck through the resourcing experience.
12. Resourcing sessions should ideally include sensorimotor or bilateral stimulation for a more enduring impact on the child.
13. The therapist should make a point of acknowledging "ah-ha" moments or moments of triumph that the child has, by recognizing the accomplishment, the courage it took to make the change, and the positive feelings and sensations related to the triumph, such as the positive shift in self-regard.
14. In the last third of the therapeutic session, and following a triumphant moment, it is often the right time for the therapist to recap and pay attention to the child's newly-evoked way of being in the world.
15. Supporting the child through the paradox of needing a guide despite coming to the realization that changes developed through resourcing were under the child's own control, will better permit the therapeutic relationship to continue to guide the child through the resourcing process.
16. A discussion around how the child might be able to take the resource, with its accompanying new perspective and put it into practice in daily life may be a helpful conclusion to a successful resourcing session. Resourcing is not resolution, but betterment as a step toward stabilization.
17. For therapists who work with younger client populations, pursuing the child's response of, "I don't know, but..." could be a very powerful point of exploration, learning, and growth.
18. Direct experience needs to be a primary focus in therapeutic resourcing, with the cognitive component of the resourcing experience encouraged in support of the direct experience.