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Chapter 1

Family and Community Contexts of Children and Adolescents Facing Crisis or Trauma

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Crises and traumatic events are ubiquitous in modern life and affect people of all ages. Contrary to the myth that the magic years of childhood are a period of guileless innocence and carefree play, the reality of the preteen years, like that of later life, includes experiences that provoke anger, jealousy, fear, and grief as well as joy and pleasure. The teen years have long been considered full of conflict and struggle as young persons grapple to resolve their identity (Erikson, 1968). When children and youth experience crises or traumas, their families and communities inevitably also are involved. Sometimes adults actually are the instigators of the victimization of children and teens, as in cases of abuse or family violence. In other situations (such as natural disasters), no one person is responsible, and the entire affected community must deal together with the shared traumatic experience.

This revised volume focuses on adolescents as well as young children who are struggling to respond to crises and/or traumatic events. The book presents the use of play and expressive therapies to help these young people cope with and resolve their difficulties. The book begins with a focus on the family and community environment in which youth live because of the critical importance of this social context to the nature of young people's reactions in crises or traumatic situations. We know that young children depend on the adults around them for security and protection, and the younger they are, the more this is the case. Adolescents may attempt to respond either independently or with the help of peers, but these efforts may fail in the face of extreme trauma. Evidence in the professional literature increasingly attests to the influence of adults' responses to crises or traumas on the subsequent nature of children's

reactions (Arroyo & Eth, 1996; Pfefferbaum, 1997; Rustemi & Karanei, 1996; Swenson et al., 1996). Because children watch and take their cues from adults, when their caregivers feel and act terrified, children become even more panicked—since they know that they themselves are helpless and powerless. Adolescents may try to act "cool" in tumultuous situations, but they can be deeply affected and traumatized nevertheless, even though they may not show immediate symptoms (Appleyard, Egeland, van Dulmen, & Stroufe, 2005).

This book recognizes and discusses the vast range of stressful and traumatic events that may impair everyday functioning and cause emotional pain to children and adolescents. The specifics of an *individual* child's or adolescent's responses, and the challenge of making a differential diagnosis, are presented by Nader in Chapter 2. The present chapter discusses the role of family and community factors in a youth's surrounding social environment that have the potential to ameliorate or worsen his or her response to a crisis or trauma. The nature of the crisis or traumatic event is also considered, since this can have differing effects on the type of support the young person receives. I have previously diagrammed the three groups of interacting factors affecting a

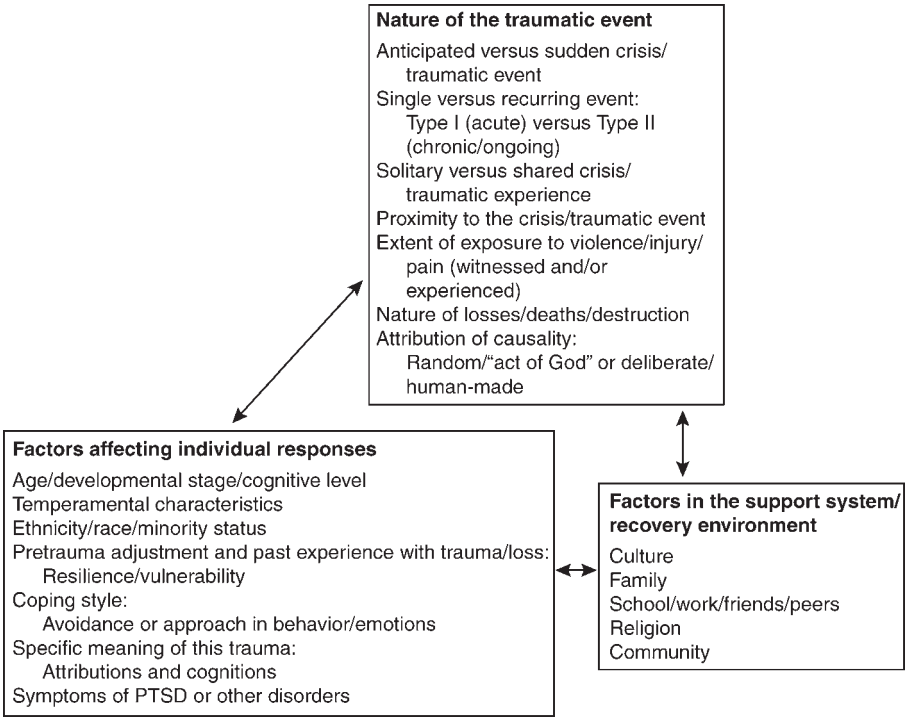

FIGURE 1.1. Interactive components of the tripartite assessment of a child's responses to a crisis/traumatic event. From Webb (2004a). Copyright 2004 by The Guilford Press. Adapted by permission.

child's responses to crisis or trauma, and have labeled the process of assessing these factors a "tripartite assessment" (Webb, 1993, 1999, 2004a, 2006, 2010, 2011; see Figure 1.1). Because this conceptualization is not age-specific, it can apply to adolescents as well as young children.

The next section presents an overview of the concepts of "stress," "crisis," and "trauma" as preliminary to examining the role of environmental risk and protective elements in buffering or escalating a young person's response to a crisis or traumatic event.

STRESS, CRISIS, AND TRAUMA

The conditions of stress, crisis, and trauma involve distinct but overlapping concepts. Whereas the "average" person (adult or child) carries out his or her life with the ability to withstand most of the ups and downs of a typical day, some people are less resilient to stress because their temperaments or their personal histories make them vulnerable. For example, an 11-year-old girl may wake up 20 minutes late and have to skip breakfast to avoid being late for school. The child in this situation feels some stress, but her stress level soon diminishes once she decides to omit her breakfast and to grab something to drink or eat on the way to school, thereby allowing her to arrive on time. In contrast, another girl in a similar situation may not see any alternative to being late; she becomes hysterical and decides not to go to school at all because she is afraid of being reprimanded for being late. Furthermore, she fears that the school will report her absence to her working mother, who will respond punitively. If we speculate that this second girl has a history of being harshly treated by her mother, we can see that the same circumstance—waking late—creates stress for both girls, but precipitates a crisis for the second girl, who may already be functioning on a marginal level because of her history of abuse. Figure 1.2 depicts the interaction and progression among the concepts of stress, crisis, and trauma.

Stress

Everyone knows how it feels to be under stress in situations that are challenging or threatening. Responses to stress may take one of three different forms: (1) attempting to get away from the uncomfortable circumstances ("flight"); (2) aggressively confronting the cause of the problem ("fight"); or (3) constricting/inhibiting one's emotional and behavioral responses ("freeze"). Selye (1978) coined the expression "fight or flight," to which "freeze" has been added by those studying behavioral reactions to dangerous situations (Blaustein & Kinniburgh, 2010).

The body under stressful circumstances actually undergoes physiological changes due to the outpouring of steroid hormones from the adrenal glands; these hormones cause increased heart and breathing rate, blood pressure,

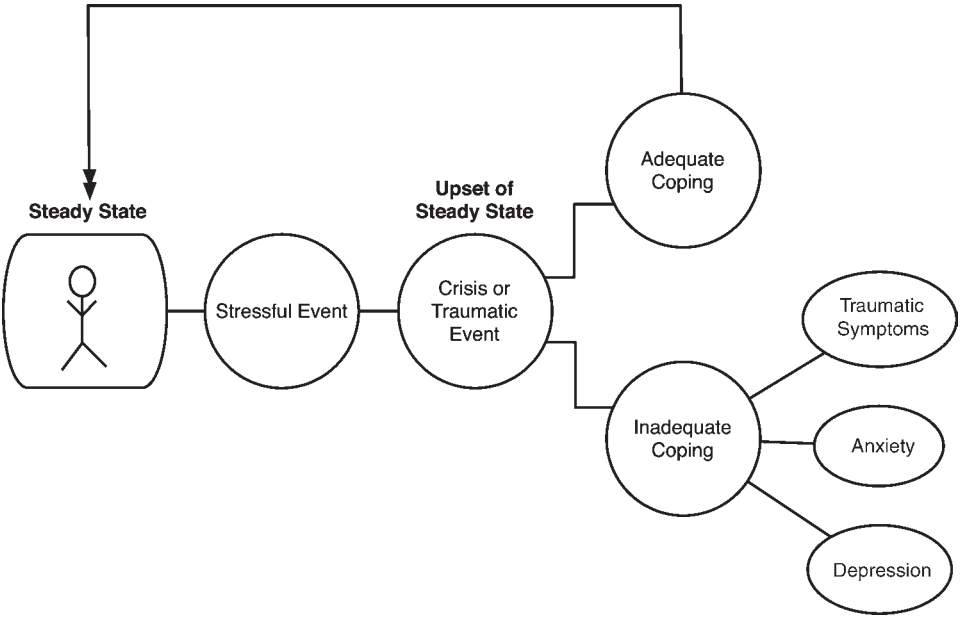

FIGURE 1.2 The interaction of stress, crisis, and trauma.

metabolic rate, and blood flow to the muscles (Benson, 2000; Selye, 1978). Although Selye maintained that stress in itself is not harmful, he pointed out that it may precipitate a state of crisis if the anxiety that accompanies it exceeds the individual's ability to function adequately.

In other words, people have different levels of stress tolerance, as well as different ways of responding to stress. Young children are particularly vulnerable to stress because of their youth, immature defenses, and lack of life experience. They often require assistance from adults to obtain relief from their anxiety and to learn new coping methods. Some adolescents under stress may rely on alcohol and drugs, and/or engage in other risky behaviors to help them cope, and these methods may actually place them at increased risk of danger (Blaustein & Kinniburgh, 2010).

Crisis

The term "crisis" refers to a situation that appears to exceed an individual's coping ability, and results in psychological disequilibrium, malfunctioning of emotions, cognition, and behavior (James & Gilliland, 2004; Roberts, 2005). The person perceives and believes that the event or situation is an intolerable difficulty that exceeds his or her resources and ability to cope. This emphasis on the *perception* of the event, rather than on the event itself, appropriately draws attention to the unique underlying meaning of the situation to each individual. As demonstrated in the case of the two girls who wake late for

school, different people experience the same situation differently, and idiosyncratic factors determine their separate perceptions of a crisis.

Another example of distinctive responses to the same stressful situation involved a group of third-grade children, following the news of the sudden death of one of their classmates in an automobile accident. All the children in the victim's class displayed some degree of shock, concern, and curiosity about the death, but individual reactions varied greatly. One child told his teacher the next day (falsely) that his father had died suddenly the previous evening. Another child complained of headaches and stomachaches for a week with no physical cause, and a third child, who was a close friend of the dead child, had frightening nightmares for several weeks about being chased by a monster. However, most of the children in the class did not develop symptoms and did not appear to be traumatized by the death (in the opinions of the teachers and the school social worker), although the child with the nightmares did benefit from six play therapy sessions, which helped reduce her anxiety. See Webb (2002) for a full discussion of this situation.

Anna Freud (1965, p. 139) stated that "traumatic events should not be taken at their face value, but should be translated into their specific meaning for the given child." I believe that the same is true of crisis events more generally. We know that different people who are present at the same event will have different responses: Not only will their experiences differ, but the individual characteristics they bring to bear upon the psychological processing are different, and *this processing takes place in differing recovery environments*. For a child or teen in crisis, the "recovery environment" holds particular significance because of the young person's dependence on family members, peers, and others to provide support and guidance. Thus the tripartite assessment of the young person in crisis includes an analysis of (1) individual factors interacting with (2) the resources of the family and the social support network, in the face of (3) a specific crisis situation.

An underlying principle of crisis intervention theory is that crises can and do happen to everyone (James & Gilliland, 2004; Parad & Parad, 1990; Webb, 1999). No previous pathology should be assumed when, for example, a child becomes withdrawn and apathetic after the child's mother is hospitalized for surgery. Although individual differences influence personal vulnerability to breakdown and the form and timing of the disturbance, no one is immune from the possibility of becoming overwhelmed in the aftermath of a crisis.

Therefore, the phrase "stress overload" seems very relevant to crisis situations, and it explains the progression from stress to a state of crisis, as depicted in Figure 1.2. The overload causes the individual to feel disorganized, confused, and panicked. When these feelings continue without relief, anxiety, depression, and/or at least some symptoms of posttraumatic stress disorder (PTSD) may develop. In fact, some theorists believe that "the degree of distress caused by an event is the major factor determining the probability of the onset of psychiatric disorder" (McFarlane, 1990, p. 70). Therefore, a crisis intervention approach that aims to lessen the anxiety of the people

involved in a crisis and to bolster their coping strategies has the potential for the primary prevention of psychiatric disorders. As we will see in many cases presented in this book, crisis intervention services are frequently short term because most crises by their very nature are time-limited. "A minimum of therapeutic intervention during the brief crisis period can often produce a maximum therapeutic effect through the use of supportive social resources and focused treatment techniques" (Parad & Parad, 1990, p. 9).

Trauma

In contrast to the possibility of brief and successful treatment of anxious individuals following crisis events, therapy for *traumatized* persons may take considerably longer. The word "trauma" comes from the Greek, meaning "wound." In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (2013) defines a traumatic event as one in which a person was exposed to threatened or actual death, grave injury, or sexual violence in any of four different circumstances: direct experience of a traumatic event; personally witnessing an event as it happened to others; learning that a traumatic event happened to a close relative or close friend; or repeated experience of exposure to painful details of a traumatic event. As mentioned previously, children often become terrified through witnessing adults in states of panic, high arousal, or frozen shock during traumatic events. The challenge of assessing a young person who has been exposed to a crisis or a traumatic event is discussed by Nader in Chapter 2.

THE NATURE OF THE CRISIS OR TRAUMATIC EVENT AND ITS IMPACT ON CONTEXTUAL SUPPORT

The tripartite assessment covers seven components that influence the nature of a crisis or traumatic situation. The present discussion focuses on how these factors may affect not only the individual, but also the type of support (or lack thereof) provided by the family and social environment. These specific components include the following:

- Anticipated versus sudden crisis/traumatic event
- Single versus recurring event: Type I (acute) versus Type II (chronic/ongoing) crisis/trauma
- Solitary versus shared crisis/traumatic experience
- Proximity to the crisis/traumatic event
- Extent of exposure to violence/injury/pain (witnessed and/or experienced)
- Nature of losses/deaths/destruction
- Attribution of causality: Random/"act of God" or deliberate/human-made

Anticipated versus Sudden Crisis/Traumatic Event

The Scout motto, "Be prepared," implies by contrast the undesirability of being caught off guard. Some events that lead to crises or traumas are by their nature unpredictable. Examples include natural disasters with no preliminary warning, the sudden death of a parent who was previously well, and the killing and injury of innocent bystanders in a wanton shooting episode. These contrast with other situations that gradually build up to a crisis or trauma. Examples of anticipated crises include a family's move to another community, the departure of the father from the home as the beginning of a marital separation, and the terminal illness of a family member. Stressful events that develop toward predictable outcomes present the opportunity for gradual comprehension and assimilation of the impending transition or loss.

However, many well-meaning adults deliberately try to shield young people from worry, and they avoid exposing them until the last minute to situations they believe will prove upsetting. For instance, they do not talk about a father's impending overseas military deployment until the day of his departure. This prevents the youth from "getting ready" psychologically, asking questions, and bracing themselves for the upcoming stressful loss. Often adults do not know how to talk with young people about future stressful matters, especially when they themselves are afraid and anxious.

The crisis techniques of "role rehearsal" and "anticipatory guidance" (Parad & Parad, 1990) aim to help individuals prepare in advance for future difficult situations. For example, a child who has advance knowledge, through pictures and explanations, about surgical masks and medical procedures shows less anxiety when confronted with these in a hospital. This mastery in advance through reflection or fantasy provides a form of psychological preparedness that ideally will lead to enhanced coping in future stressful situations. A folk saying claims that "a job well dreaded is more than half done." Even though the dreading is unpleasant, it permits anticipatory problem solving and emotional preparation. Parents, teachers, and community members who have contact with children and teens should be encouraged not to shield them, but to help prepare them for possible future stressful life experiences, and to assist them in talking about and dealing with their current worries as well.

Single versus Recurring Crisis/Trauma Events: Type I versus Type II Trauma and the Diagnosis of Complex Trauma

The notion of the "straw that breaks the camel's back" suggests that accumulated stress may weigh so heavily on a person that not even one minor additional stress can be tolerated. Thus the precipitating factor in a crisis may not be as significant as the events that have preceded it and created a "vulnerable state" for the individual. For example, a child who has suffered repeated physical abuse may respond aggressively after a relatively minor occurrence,

such as a reprimand from a teacher, because of the child's preexisting vulnerable state.

Terr (1991) has proposed the concepts of "Type I" trauma, which occurs following *one* sudden shock, and of "Type II" trauma, which is "precipitated by a *series* of external blows" (p. 19; emphasis added). Responses to Type I traumas may include detailed memories and misperceptions about what happened, whereas reactions to Type II traumas often involve denial, numbing, dissociation, and rage. Sometimes the two types of traumas coexist. When untreated, either type can lead to serious disorders in both children and adults, but this is particularly true of Type II. For example, common sense suggests that the witnessing of a teacher's murder may have very different repercussions for a young person whose development is proceeding normally and whose parents offer appropriate comfort and support, as compared with a teen who lives in a dangerous neighborhood where guns and violence are commonplace and whose older siblings talk about needing a gun for self-protection. In most circumstances, Type I traumas do not lead to long-term symptoms, and recovery occurs in more than three-quarters of cases, even after very tragic experiences (Cohen, 2004; McFarlane, 1990). Type II traumas take much longer to resolve, however, and may require long-term treatment.

The term "complex trauma" refers to multiple, chronic, relational traumas such as abuse, neglect, violence, and parental misattunement, which begin in early childhood and which are usually ongoing and interpersonal (Herman, 1992; Kliethermes & Wamser, 2012; Shelby, Aranda, Asbill, & Gallagher, 2015). Because about one-fifth of youth in the United States have been exposed to more than one type of victimization (Grasso, Greene, & Ford, 2013), and the initial exposure typically occurs at about 5 years of age, this may mean that complex trauma is a relatively common condition in youth (Shelby et al., 2015). The symptoms may include various forms of emotional dysregulation, somatatization, and aggressive behavior (Saxe, MacDonald, & Ellis, 2007). Although this condition has been studied primarily in adults (Nader, 2008), there is growing attention to the assessment and treatment of this condition in children and adolescents (Kliethermes & Wamser, 2012). In Chapter 12 of this book, Haen discusses group treatment for adolescents who have been diagnosed with complex trauma.

Solitary versus Shared Crisis/Traumatic Experience

If "misery loves company," then we would expect the sharing of a crisis or traumatic experience to offer a degree of comfort and support that is absent when an individual undergoes such a stressful crisis alone. Certainly the dynamic of guilt ("What did *I* do that caused this?") and issues of personal responsibility ("What *should* I have done?") are irrelevant or greatly reduced in shared situations. Although every crisis or traumatic event is experienced ultimately on a personal level, the knowledge that others are enduring similar turmoil may reduce the stigma of victimization. For example, a child victim of

incest may gain extraordinary benefits from participation in a support group of similarly victimized children.

However, the commonality of a shared crisis or traumatic event does not automatically lead to bonding among the individuals involved. Terr (1979), reporting on the aftermath of the kidnapping of a school bus of summer school students, found that the traumatized youngsters avoided contact with one another after the horrible experience was over. As if to escape the memories of their ordeal, these children tried to blend into the community and to stay away from the students who had shared the trauma and who reminded them of the frightening experience. This type of avoidance was also noted by many group therapists who unsuccessfully attempted to convene bereavement support groups soon after the New York World Trade Center terrorist attacks of September 11, 2001 (Hartley, 2004). Avoidance is one of the characteristics of PTSD, as discussed below.

Age is a crucial factor in determining the extent to which the sharing of a crisis or traumatic situation helps children. Whereas peer support may be very crucial for adolescents, the influence of peers is not strong until the middle years of elementary school. Preschool children rely on their familiar adult caregivers, rather than on peers, to provide them comfort and security when they are upset. Unfortunately, parents and teachers often minimize children's anxious responses (La Greca & Prinstein, 2002) thereby increasing the likelihood that children in distress will not receive timely treatment.

Proximity to the Crisis/Traumatic Event

A research study in California following a sniper attack in a school playground (Pynoos & Nader, 1989) found that children who were in closer physical proximity to the shooting developed more symptoms of PTSD than children who were on the periphery or not on the playground when the attack occurred. Proximity to the shooting resulted in more severe responses, both soon after the event and 14 months later (Nader, Pynoos, Fairbanks, & Frederick, 1990). These findings, which seem intuitively valid, confirm that proximity to a crisis or traumatic event results in intense sensory responses together with a heightened sense of life threat, all of which can contribute to symptom formation.

However, as I have written previously (Webb, 2004b, p. 8), "proximity can be viewed as emotional, as well as geographic." Many employees who worked in the New York World Trade Center lived some distance from ground zero. Their family members who watched the disastrous events of 9/11 on television were clearly in close "emotional proximity" to the traumatic events. In fact, in this age of high media exposure, even very young children may watch horrific events such as the World Trade Center's destruction, and see such things as the clouds of smoke and people jumping from buildings to escape. Research after both the Oklahoma City bombing of 1995 and the 9/11 attacks showed an association between televised coverage of the terrorist events and children's adverse psychological outcomes (Pfefferbaum et al., 2004). These

exposure experiences may qualify as "vicarious traumatization" (McCann & Pearlman, 1990), since they involve auditory and visual scenes of horror. Unfortunately, many families did not protect their children from watching repeated media replays of these traumatic events, and some children became very confused and troubled by seeing them. In these instances, "proximity to the event" occurred within their own living rooms!

Extent of Exposure to Violence/Injury/Pain (Witnessed and/or Experienced)

As the preceding discussion suggests, we live in a violent world that does not shield children from graphic exposure to conflict in all forms and locales, including the family, school, and community. American society seems to have a high baseline tolerance for violence, which within the family takes the form of child abuse, spouse or partner abuse, incest, and other assault episodes. Pynoos and Eth (1985, p. 19) believe that "children who witness extreme acts of violence represent a population at significant risk of developing anxiety, depressive, phobic, conduct, and posttraumatic stress disorders." (This risk, of course, is even higher when children are themselves the victims of such violent acts.) Indeed, the presence of severe threat to human life in which the individual's response involves intense fear, helplessness, and horror constitutes the precondition for a traumatic experience in the DSM-5 diagnosis of PTSD, as I have noted earlier and as discussed by Nader in Chapter 2.

Child witnesses typically experience a sense of helplessness and confusion when confronted with human-induced acts of violence. Especially when these traumatic events occur in their own families, children become flooded with feelings of anger, vulnerability, and fear because they realize that the very people who are supposed to love and protect them are instead deliberately hurting them or other family members. This usually interferes with the development of a secure attachment relationship (Davies, 2004, 2011).

When violence results in deaths—as, for example, in the school shootings of 20 children in Newtown, Connecticut—the community and newspapers may sensationalize the event, and the people involved may feel overwhelmed by an emotional battery of reactions, including anger, hatred, and guilt (see Miller, Chapter 14, this volume). Although a family can help a child survivor by ensuring his or her safety and protection after the traumatic situation is over, the pupils who witnessed the deaths of their classmates and feared for their own lives will not easily forget this, and many will need specialized treatment to help them deal with their traumatic memories (Rivera, 2013). Fortunately, schools have become more attuned to the wisdom of providing some form of psychological debriefing or first aid to students following a school-based crisis or trauma such as the Newtown event, but often witnesses will still require individual treatment. In Chapter 14, Miller discusses appropriate school interventions following violent and traumatic events.

Nature of Losses/Deaths/Destruction

Losses play a major role in many crises and traumatic situations, and the associated reactions of confusion, anger, and desperation may be understood as mourning responses associated with the losses. When the losses include death of or separation from family members, grief and mourning are appropriate responses. Less obvious losses occur in situations such as moving or school promotion, which require giving up a familiar location or status and developing new relationships. Teachers can attest to the high level of anxiety in September until children become comfortable with the expectations and people in their new grade. This anxiety usually does not cause a state of crisis for most youth, but it can put them into a vulnerable state in which their ability to cope is reduced temporarily. Even adolescents may be uncomfortable in a new grade until they become accustomed to their schedules and their different teachers.

The converse of loss is attachment. If no positive bonding existed, no mourning would be necessary. Bowlby's (1969) seminal work on attachment highlighted the biological source of the need for proximity in human relationships, with the prototype of attachment being the mother–infant relationship. Although object constancy permits the mental retention of loved persons in the memory, nonetheless a child whose parents separate and/or divorce is deprived of daily contact with one of his or her attachment figures, and thus suffers the loss both of this person and that of the intact nuclear family. Other losses following divorce often include a change of residence, school, and lifestyle. But it is the loss of contact with an attachment object (the nonresident parent) that results in the most serious deprivation for children. Multiple losses cause multiple stressors, adding to the potential for crisis.

Illness, although a common occurrence in growing up, may involve a number of temporary or permanent restrictions on a young person's life, which he or she may experience as losses. A youth with a terminal illness, for example, must adapt to bodily changes, environmental restrictions, changed expectations for the future, and changed relationships. These all constitute losses. Physical injury or pain constitutes a serious threat to a youth's basic sense of body integrity, compounding the other stresses associated with medical treatment. The family has an important role in helping the child cope with a serious medical crisis. (See Gilbert & Hong, Chapter 15, this volume, for further discussion.)

Losses constitute a significant component of a crisis or traumatic event. Both losses that are "vague," such as the loss of a sense of predictability about the environment (e.g., following a tsunami or terrorist attack), and more evident or specific losses, such as the death of a pet, can create stress and anxiety. In addition, memories of past experiences of loss and bereavement often become reawakened in current loss situations, thereby complicating the individual's responses.

Attribution of Causality: Random/"Act of God" or Deliberate/Human-Made

People often seek to attach blame after something "bad" happens. For example, because preschool children are naturally egocentric, such a child may believe that something he or she did or did not do caused a parent's death. As children grow, their understanding becomes more mature and sometimes reveals their search for logical reasons for tragic events. This was illustrated by an 8-year-old boy who asked in disbelief following the 9/11 attacks, "Why did they do it, when *we* taught them to fly?" (Webb, 2004b, p. 10). The child's black-and-white sense of right and wrong was shattered, and this may have led to erosion of this boy's faith in human nature. An older child usually has more understanding about the complexity of human behavior and motivation, including the reality of deliberate malevolent actions. This awareness may lead to disillusionment about other people and increased anxiety about the safety of the world. Of course, sensitive caregivers can buffer children and teens' anxiety by reassuring them that the current experience is not typical of *all* people, and that goodness exceeds evil in the world.

As compared with a terrorist or other human-made act, when a crisis/traumatic event occurs as the result of a seemingly random occurrence or "act of God," the element of blame is often less intense. Many adults respond with a kind of fatalistic attitude that there is nothing anyone could have done to prevent this type of crisis. This acceptance makes the resulting grief less complicated. However, blaming still may occur with regard to the management of disaster relief efforts. For example, in the aftermath of Hurricane Katrina in 2005, many people complained about inadequate government intervention to alleviate their suffering, and thousands of families were subjected to both physical and emotional pain as a result of the massive dislocation and destruction they witnessed and experienced after the disaster.

CONTEXTUAL ELEMENTS THAT HELP OR HINDER YOUTH IN CRISIS AND TRAUMATIC SITUATIONS

A crisis happens to a specific individual within the context of his or her social and physical environment. I now consider some of the features of this contextual surround that may either help or hinder a child or adolescent in crisis. The nature of the support system is particularly important for children in crisis/traumatic situations because their youth and dependence make them especially reliant on others to assist them (Pfefferbaum et al., 2004).

Culture and Religion

The term "culture" encompasses the beliefs, values, morals, customs, and world views that are held in common by a group and to which its members are

expected to conform (Webb, 2001). Cultural values pervade all aspects of life and are often shaped by specific religious practices and beliefs. For example, the responses of many Buddhists following the December 2004 tsunami in the Far East reflected their fatalistic belief in karma, with the acceptance of such events as part of the cycle of life. In striking contrast, many fundamentalist Christians in south Florida after Hurricane Hugo in 1989 attributed the storm to God's intent to "teach them a lesson." These different perceptions demonstrate how culture and religion constitute the lenses through which people view their worlds.

Whereas all people experience stress, their culture determines whether and in what manner they acknowledge this distress. For example, Fang and Chen (2004) reported the case of Chinese parents living in New York after the 9/11 World Trade Center bombing who were unable to understand their daughter's traumatic nightmares and school failure as part of the girl's anxiety reaction. They did not want her to consult the school psychologist about her poor grades and difficulty concentrating because the parents considered that this would reveal the girl's "weakness" and therefore "shame" the family. Psychological problems are considered disgraceful in some cultures, and the challenge for counselors and therapists is to find a way to frame these difficulties in terms of "normal" responses in difficult situations (Nader, Dubrow, & Stamm, 1999). The cultural and religious backgrounds of different groups influence both the way a crisis or traumatic event is perceived and the nature of the response (McGoldrick, Giordano, & Garcia-Preto, 2005). McGoldrick (1982, p. 6) states categorically that "the language and customs of a culture will influence whether or not a symptom is labeled a problem . . . [and that] problems can be neither diagnosed nor treated without understanding the frame of reference of the person seeking help as well as that of the helper."

Thus it is imperative for a therapist to identify and weigh the significance of cultural and religious factors in trying to understand a family's reaction to a crisis or traumatic situation. In the previous example, had the school social worker telephoned the Chinese parents and suggested that they seek a mental health evaluation for their daughter, the parents would have felt disgraced and angry, and they probably would have declined the suggestion and blamed their daughter for speaking about her problem to outsiders. However, had the social worker stated that she was sending *all* parents some information about the typical reactions of children and youth after disasters, and then pointed out that it was important to help children so that their schoolwork did not suffer, the chances of parental cooperation would have been far greater.

Nuclear and Extended Family

Most people seek out their close family members at times of crisis, either directly or via telephone or electronic communication. Proximity seeking is a hallmark of attachment. Young children are no exception, and in stressful situations they cry for their mothers (or other primary caregivers) and cling to

them for comfort. The nature of the mothers' responses, in turn, has a strong influence on how the children will react—even during the stresses of wartime. Freud and Burlingham (1943) reported that children who remained with their mothers in London during the Blitz of World War II fared better than those who were evacuated to the countryside, where they lived more safely but with strangers. When parents remain calm, their children tend to follow suit. However, this places a great burden on parents who themselves may be traumatized. Even in a noncrisis situation, parents may be preoccupied with financial worries, professional concerns, or other matters that can significantly diminish their availablity to their children.

A "genogram" is the starting point for identifying all family members who potentially can provide support to a child in crisis. In the process of creating a three-generation genogram with the family, the crisis therapist learns not only the names of family members, but also their geographic location, their frequency of contact with one another, and something about the quality of their various relationships. It is helpful to ask parents in completing the genogram, "Of all these various family members, which ones do you consider most important to your children?" The response sometimes reveals the influence of an aunt or uncle, which might not otherwise be known.

The family members' demographic characteristics (e.g., age, socioeconomic status, level of education), in addition to their cultural characteristics, often affect the particular ways they respond to a crisis or trauma. In particular, we must recognize that children growing up in impoverished families frequently lack support from their parents, who may be under financial stress and suffer more depression and psychological distress than do more affluent parents (Huston, 1995). Therefore, children who most need adult protection, due to dangerous inner-city neighborhoods with very high levels of interpersonal violence, may not have this resource (Fick, Osofsky, & Lewis, 1994). The ideal of a safe, nurturing, supportive environment is far from the reality of many young people in poverty.

School, Friends, and Community Supports

An "eco-map" (Hartman, 1978) provides a diagrammatic tool for illustrating the available types of support surrounding a family or household. The eco-map provides an excellent means of analyzing potential resources in a young person's network of friends, church, school, health care, and other institutions.

The Beatles sang about getting by "with a little help from my friends," and this continues to be true for those fortunate enough to have caring friends who can help. It is not surprising that more supportive environments tend to be associated with a better adjustment to stressful situations.

Beyond the family circle, the school can serve as either a refuge or a source of dread for a young person, depending on the degree to which he or she feels comfortable in the classroom setting and especially in the peer

environment. School-age children and teens typically seek out friends who are similar to themselves. This friendship group broadens a young person's sphere of contacts outside the family, and sometimes provides an important source of support at times when the youth's own family members may be caught up in their own conflicts, such as separation and divorce (Davies, 2011). On the other hand, a young person who does not fit in at school may suffer the effects of negative peer contacts, which can cause him or her to dread going to school for fear of ostracism or bullying. In Chapter 13 of this book, Swearer, Schwartz, and Garcia deal with this situation more fully.

Community problems can affect children to varying degrees, depending on their scope and meaning to the child. For example, a youngster living in a run-down tenement building surrounded by gang warfare will probably react more strongly if he or she witnesses a shooting than will a child the same age who lives in a safe neighborhood. The first child realizes (probably not for the first time) that his or her neighborhood is not safe, and therefore this child may experience an increased sense of vulnerability. Children in this situation may benefit greatly from community programs in which they can participate in sports, recreation, or church activities under the careful supervision of coaches, teachers, or religious leaders, who serve as both protectors and positive role models. Unfortunately, all too frequently communities in poor neighborhoods lack the kind of after-school activities that could assist underprivileged youth to grow up with positive views about themselves and their world.

CONCLUDING COMMENTS

The term "resilient" has been used to describe individuals who demonstrate successful adaptation despite high-risk status, chronic stress, or prolonged or severe trauma (Egeland, Carlson, & Stroufe, 1993; Garmezy, 1993; Masten, Best, & Garmezy, 1990). "Resilience" is defined as "the ability to recover readily from illness, depression, adversity, or the like" (*Webster's College Dictionary*, 1968, p. 1146). If we consider resilience to be an *internal* capacity, we must also acknowledge that this ability inevitably interacts with *external* factors, which may be either nurturing and supportive or difficult and depriving (or some combination of the two). Thus resilience is a transactional *process* that "develops over time in the context of environmental support" (Egeland et al., 1993, p. 518).

However, the existence of risk factors such as poverty, parental divorce, parental substance misuse, or parental mental illness by no means sentences a young person to negative life outcomes, according to Rak and Patterson (1996). These authors optimistically report that protective factors, such as individual temperament and unexpected sources of support in the family and community, can buffer a youngster who is at high risk and help him or her succeed in life. See Davies (2011) for a full discussion of the intricacies and

interrelationship among risk and protective factors in the child, the family, and the community.

Clearly, multiple factors affect each child and adolescent in each situation—factors that the tripartite assessment summarizes. Consideration of the numerous elements that help or hinder a young person's unique adaptation in different crisis situations constitutes the heart of understanding. And, ideally, such understanding will lead to appropriate assessment and treatment, as we will see in the following chapters.

STUDY QUESTIONS

1. What are some options a counselor can employ to help a young person from an abusive family who lives in a poor and violence-prone community?
2. Discuss the impact on a child of living in a deeply religious family that does not approve of after-school activities such as participating in sports and social events. Can you suggest some ways to convince the parents that these activities might be beneficial for their child?
3. How can a counselor/social worker help family members deal with negative behavior toward them and their children based on racial prejudice?
4. List some methods to help influence a child not to join a gang or participate in antisocial activities.

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