2009

Practitioners' Views of Effective Treatment Options for Childhood Trauma

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Degree Type
Open Access Senior Honors Thesis

Department
Social Work

Subject Categories
Social Work

PRACTITIONERS' VIEWS OF EFFECTIVE TREATMENT OPTIONS FOR CHILDHOOD TRAUMA

BY

MARY SUE STORIE

A SENIOR HONORS THESIS

Acknowledgements

This project has been a big undertaking and has been made possible through the love and support of friends, colleagues and mentors. I owe a debt of gratitude to my friends, Pam, Herb, Lynn, Jess, Renee, Paul, Addison, Luisa, and Dr. T. The completion of this project was made possible through the numerous professionals who generously contributed their time and expertise to my research. My first mentor Dr. Ragg guided me in putting my passion into a concept. Dr. Wedenoja helped me articulate and run with my vision. Dr. Walters helped me reel in my expectations, keep my sanity, and bring this work to a close. Dr. Gray encouraged me to press on. My sincere thanks to the McNair staff, the honors college, my McNair colleagues, Karen Busch, the staff in the faculty development center, and to Keith Stanger.

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ABSTRACT

In today's society the number of children who experience childhood trauma is increasing significantly. As a result of this increase, the number of people seeking treatment is also on the rise. For this study, data were collected using both qualitative interviews (N=10) and an online quantitative survey (N=32). Practitioners' views of effectiveness ranged from both more traditional treatments to emerging alternative treatments. Recent knowledge from brain research shows trauma impacts both the left and right side of the brain. Many practitioners noted effective treatment needs to be comprehensive. This is supported by literature recommending modalities that work with the effect trauma has on both sides of the brain.

INTRODUCTION

In today's society the numbers of children who experience childhood trauma is substantially increasing in numbers. Childhood trauma is on the rise and affects children around the world (National Child Traumatic Stress Network, 1995,1997,2002,2004). Although the traumatic event happens in childhood, there may not be any adverse effects until months or even years later. This study used Greenwald's definition of trauma, "applies to major trauma as well as loss and other adverse life events, as long as the event has had a traumalike impact on the child" Greenwald (2005, p. 10). Practitioners' shared their observations along with their wisdom from working with childhood trauma. This study focused on similarities and differences among providers who work with childhood trauma. The survey summarized the opinions and experiences of health care professionals, including social workers, physicians, and educators. Further data were gathered through online surveys sent to similar professionals working with similar clients. The survey gathered primarily quantitative information, while the interviews collected primarily qualitative data. Various treatments were rated for their effectiveness according to the professionals' experience and opinion.

LITERATURE REVIEW

WHAT IS TRAUMA?

Trauma has many definitions depending on what literature you read. The Greek word for trauma means "an injury or wound to a living body caused by the application of external force or violence." Another definition is, "a psychological or emotional stress or blow that may produce disordered feelings or behavior" (Webster's Third New international Dictionary, 2002, p. 2432). Trauma affects the whole body, "Emotional trauma has a physical impact; physical trauma carries an emotional impact" (Timms & Connors, 1992, p. 6). Trauma has symptoms that can produce difficulty functioning and debilitating effects (Levine, 2005; Wainrib, 2006; Greenwald, 2005). Although definitions of trauma differ, all definitions reflect various types of trauma and the impact trauma has.

WHAT ARE THE AFFECTS OF TRAUMA?

People who have experienced childhood trauma often respond in a way that others might not have any adverse reaction to (Allen, 2005, Solomon & Siegel, 2003). Trauma, childhood trauma in particular, has a multi-dimensional impact that can affect a person on a cognitive, behavioral, emotional, and psychobiological level and has consequences on development. This impact can distort or impair a person's ability to function, to form and maintain relationships, and the ability to make healthy attachments or connections with others. The symptoms of trauma

include, avoidance, denial, dissociation, feelings of helplessness immobility, intrusion of thoughts and feelings, numbing, hyper arousal, a fight, flight, or freeze response and may also be accompanied be a compulsion or draw to repeat the trauma (Levine, 2005; Wainrib, 2006; Wilson, Friedman, & Lindy, 2001). Trauma may have a psychophysical effect, even if no harm was caused to the body. As van der Kolk illustrates in title of his article, "The body keeps score" (van der Kolk 2004, p. 105).

PTSD AS THE RESULT OF TRAUMA

Posttraumatic stress disorder (PTSD) is one of the most common mental illnesses and may include those who have experienced childhood trauma (van der Kolk, McFarlane, et al., 1996).

> The essential feature for PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury…The persons response to the event must involve intense fear, helplessness or horror (in children the response must include disorganized or agitated behavior). (APA, 2000 p. 463)

People who experience PTSD may lose the ability to employ their emotions as guides for action (van der Kolk) 1984.

CHILDHOOD TRAUMA AND THE IMPACT ON NEURODEVELOPMENT

New knowledge from brain research reveals a connection between childhood trauma and neurodevelopment. A child's experiences during the developmental stages influence function, organization, and development of the brain (Perry et al, 1995). Mental processes are formed through the activity of the brain, which creates an individuals "interpersonal neurobiology" (Solomon, Siegel, 2003). The amygdala in the temporal lobe of the brain plays a part in processing stimuli with emotional and social significance. The amygdala expresses a high level of activation in response to threat, and initiates an unconscious fear response. It also has a role in learning cues associated with danger. Hardwired or unconscious responses are unyielding reactions that set a pattern, and must be counterbalanced by thought and action. Heightened arousal experienced from the fear response can be an overriding factor to thought and action (Adolphs et al. 2002; Alan, 2005).

Some researchers believe both the left and right prefrontal cortex play a role in memory recall and cognition. Nonverbal processing and communication require right brain processing while another region affects perception, expression, and emotional processing (St. Jacques et al. 2008; Borod 1992). Studies propose those who experience trauma as children and those with PTSD have an increased activation of the amyglada are unable to integrate their perceptions and sensations related to the trauma and their unconscious responses to their memory and leads to overall fearful behavior (Lanius et al., 2006; van der Kolk, Pelcovitz et al., 1996). The brain is

very complex and it is important to understand the impact trauma has on the mind in order to help the healing process occur (Solomon & Siegel, 2003).

VARIOUS TYPES OF TREATMENT MODALITIES

Complimentary alternative modalities (CAM), for trauma therapy such as eye movement desensitization and reprocessing (EMDR), Somatic Experiencing (SE), play, art, and music therapies activate the amygdala in the limbic system. The limbic system governs the social and emotional input that links with the prefrontal cortex while traditional talk therapy access the cognitive side of the brain (Talwar, 2007). In traditional talk therapy and CBT verbal processing is required accessing only one side of the brain. Nonverbal creative therapies have the ability to access the trauma at a different and deeper level than verbal related therapies. A common goal using CAM is to lead people to emotions, feelings, and senses not accessible through their conscious minds (Alan 2005; Levine 1997; Talwar 2007). EMDR also uses both sides of the brain and is an up and coming popular treatment that many professionals use. There have been considerable research studies done on the effectiveness of EMDR in adults, currently more studies are being conducted on the effectiveness of EMDR with children (Jaberghaderi et al., 2004; de Roos et al., 2006). The majority of practitioners formally trained in the use of EMDR view EMDR to have less risks than other alternative treatments used of treating trauma (Lipke, 1994). According to Levine, "Somatic Experiencing is a gentle step-by-step approach to the renegotiation of trauma. The felt sense is the vehicle used to contact and gradually mobilize the powerful forces bound in traumatic symptoms" (Levine 1997, p. 120). Somatic Experiencing access both sides of the brain and has the ability to access trauma that has been stored in a person's physiology. Somatic Experiencing facilitates the release of the stored or frozen energy that remains in the body.

METHODS

Mixed methods research were used for this study, and consisted of in-depth qualitative interviews and quantitative online surveys. Sampling began with a convenience sample of local practitioners who were in the Washtenaw County area of Michigan. It then became a snowball sample, as the practitioners referred me to others who specialized in childhood trauma. In addition to the ten interviews, online surveys were sent to eighty health care professionals in a variety of states.

SURVEY SAMPLING

The e-mail addresses for the surveys were obtained through a snowball sample, online search, and through advertisements. The criteria for the search were licensed practitioners who identified themselves as working with childhood trauma. The survey designed was created by

the researcher in Survey Monkey, an online web-based tool that allows users to create a survey, poll participants, and analyze the data. The survey contained fourteen primarily quantitative questions and consisted of a demographic section and a section that asked questions about their current practice. To view the survey see, Appendix A. An e-mail, which contained a link to the survey, was then sent to the e-mail addresses that were obtained. The surveys consisted of a demographic section that asked age, gender, and ethnicity. The following section focused on practice questions such as, current profession, practice setting, years in practice, types of childhood trauma currently being treated, and the types and effectiveness of modalities used. The survey responses had no identifying information therefore were anonymous and assured confidentiality. In all thirty-two survey responses were obtained. Survey Monkey was used to analyze the survey data. The data obtained from the Survey Monkey was then entered into SPSS quantitative data analysis software.

SURVEY DEMOGRAPHICS

The survey participants consisted of seventy-eight percent females and twenty-two percent males. Thirty-eight percent of the participants were between the age of forty to forty-nine, twenty-eight percent between thirty and thirty-nine, twenty-five percent between fifty and fifty-nine, six percent were twenty to twenty-nine, and three percent were sixty or over. Ninety-one percent of the participants were Caucasian, six percent, Hispanic/Latino, and three percent Asian. Of the thirty-two professionals sixty-three percent were social workers, sixteen percent psychologists, nine percent educators, six percent medical doctors, and six percent psychiatrists. Forty-one percent of the practitioners worked in private practice, twenty-two percent in a not-for-profit agency, thirteen percent worked in multiple settings, and six percent each in educational setting, clinic, hospital, and public or governmental organizations. The average length of practice time for the providers surveyed was fourteen years in their current practice, with a thirty-five year range.

INTERVIEW SAMPLING

The interview participants were selected based on convenience. Participants selected were in the researcher's local area, Ann Arbor, Michigan, and were known to specialize in childhood trauma. Thirty percent of those surveyed were the result of recommendations from other practitioners who participated in the survey. The practitioners were contacted by phone to ask if they were willing to participate in the survey, if so the interview was then scheduled. Primarily the interviews were conducted at the practitioners practice, and were approximately thirty-five minutes in length. The interview consisted of five questions, see appendix B for the interview questions. The interviews were recorded and then transcribed and analyzed from the transcriptions.

INTERVIEW DEMOGRAPHICS

The interview participants consisted of seventy percent female and thirty percent males. Fifty percent of the practitioners were social workers with master's degrees, twenty percent were educators, twenty percent were physicians (one internist and one psychiatrist), and ten percent psychologists. Eighty percent of the participants were Caucasian and twenty percent Hispanic/Latino. Forty percent of the participants were between the age of thirty and thirty-nine years old, thirty percent were between the ages of forty and forty-nine, twenty percent were between fifty and fifty-nine, and ten percent were over sixty. Fifty percent of the participants were in private practice, thirty percent in public or governmental agency, and ten percent in an educational setting, and ten percent in a not-for-profit agency.

FINDINGS

SURVEY FINDINGS

EMDR effectiveness and comments

Thirty-four percent of practitioner's rated the effectiveness of EMDR. Six percent rated EMDR as very effective, nine percent rated it effective, sixteen percent rated it rarely effective, three percent labeled it never effective, and sixty-six percent did not enter a response. Twenty-two percent of practitioners made a comment that EMDR seemed to be effective although they were not personally trained in EMDR. Of the thirty-two practitioners two use EMDR often, two sometimes use it, and one rarely uses it, twenty never use it, and seven did not enter a response. One practitioner who has used EMDR since 1999 had the following to say:

> I started doing EMDR and working with trauma in that way, childhood and other. In the last few years we have become interested in doing it [EMDR] with children. It would be the most wonderful thing if we could help heal these issues early on. The goal would be to get them back onto their developmental track and not to carry all of the wounds with them. To see the practitioners views of the effectiveness of EMDR see appendix E.

Other modalities listed

In addition to rating the effectiveness of the treatment options listed on the survey sixteen practitioners listed other treatment modalities. All practitioners' rated their method of "other" treatments as either effective or very effective. The therapies listed were: (see appendix D for definitions of treatment modalities)

- stress management (3)*
- role play (2)
- bioenergetics analysis (2)
- drama (2)

- dyadic development psychotherapy (2)
- thera-play (2)
- focusing (Gendlin) (1)
- crisis intervention (1)
- parent-child psychotherapy (1)
- prayer (1)
- pre-therapy (Prouty) (1)
- sensory motor psychotherapy (1)
- sound therapy (1)
- touch therapy (1)
- Transformative Insight Imagery (1)
- verbal toning (1)

*The number listed in ( ) is the number of practitioners who listed that treatment modality in "other" treatments.

INTERVIEW FINDINGS

Practitioners' views of effectiveness of treatments

Two physicians, one psychiatrist and one internist, who treat patients with a history of childhood trauma, were interviewed. In the medical model, medication is used to treat these clients. Both physicians said that the average effectiveness of these medications to treat the symptoms rated 2 or 3 on a scale of 1-5, 1 being not effective and 5 being very effective, with direct comments about it's ineffectiveness to treat patients in the absence of psychotherapy or other treatment modalities. The psychiatrist stated: "I think in terms of childhood trauma, specifically, I would say that medication is often important just in terms of maintaining a certain level of emotional stability for ability to function in daily life. But it doesn't really get to the root of the problem. The internist made a similar comment stating, "I think medication as a primary treatment for that [childhood trauma] is less effective. It treats symptoms but it doesn't treat the underlying issue." A social worker interviewed had the following to say about the use of medication for the treatment of childhood trauma.

> I don't think medication treats childhood trauma. I think it can help manage panic or anxiety. I think it can help with depression. I think it can help with some of the physical disorders that come into play because of childhood trauma, but I don't think it helps childhood trauma.

See appendix C for intervention effectiveness ratings. N represents the number of practitioners who rated the effectiveness of that particular treatment and the mean represents the effectiveness rating on a scale of 1 to 5, 1 being not effective and 5 being very effective. The treatment modalities are listed in descending order according the highest rating of effectiveness.

Specialized training for the treatment of childhood trauma

Participants were asked, "what specialized training have you received to prepare you for working in the area of childhood trauma. All practitioners expressed that they received little to no training in the area of childhood trauma as part of their coursework. However, five out of ten practitioners stated that their primary skills and experience were developed in their practice when they had a client who had experienced childhood trauma, leaving them to "figure it out" on their own. Eight practitioners talked about their pursuit to learn more about childhood trauma, the methods used were seminars, special trainings, and mentorship with an experienced practitioner.

Practitioners' recommendations for improvements in the treatment of childhood trauma

Traditional therapies including psychotherapy, family and group therapy, cognitive behavioral therapy, and medication therapy are commonly used to treat PTSD and childhood trauma. Traditional treatments are the focus of education both on the bachelors and master's level. When Practitioners were asked what improvements they would like to see in the area of childhood trauma, both doctors agreed, earlier detection, better training in undergraduate and graduate medical education, specialized training dealing with new treatment modalities, and that physicians need to ask about childhood trauma and to ask about it in a skillful way. One doctor stated, "Sadly what is common is that doctors don't even ask the right questions… many are unskilled or uncomfortable asking about it [childhood trauma] so if you are uncomfortable, unskilled and untrained in asking about it you're not likely to ask about it. You don't have to know how to treat it, just know someone who knows how to treat it". An educator interviewed would like to see teachers and other professionals have an understanding of the importance of building relationships. "When working with childhood trauma you need an understanding of basic development for whatever age you are working with".

DISCUSSION

Recent brain imaging studies reveal one's life experiences during early developmental stages alters the brain. Early development has a significant influence on one's interpersonal neurobiology. Therefore, childhood trauma can have a lifelong impact on an individual. The effects can have physiological, social, and psychological implications. The aphorism biography = biology would explain the impact of trauma on brain development. These findings suggest the effectiveness of utilizing multiple modalities to address the multi-dimensional repercussions of childhood trauma. This would include modalities that access both sides of the brain, as well as modalities, which work with the physiological aftermath that result from the trauma.

Brain studies reveal non-verbal processing and communication happens on the right side of the brain and other regions of the brain effect perceptions, expression and emotional processing. When traditional therapy is the only type of treatment used, only the non-verbal processing and communication characteristics are being addressed. If medication is used for the treatment of childhood trauma, the data suggests this does not resolve the problem but only treats the symptoms. Therefore complimentary alternative modalities in addition to traditional therapy may prove more effective and yield better results.

This research suggested the longer a provider had been in practice the less likely they were to be trained in alternative modalities. Although some providers did mention referring out for alternative treatments such as EMDR, a single provider may be limited in the complimentary alternative modalities they can offer. As the emerging brain studies reveal the effects of trauma on brain development, more research needs to be conducted to examine the effectiveness of current treatment options and the further development of alternative modalities.

LIMITATIONS

This study had several limitations. A major limiting factor was time. This entire study was conducted over a ten-week period of time. The time constraint limited the amount of interviews and surveys that could be conducted, as well as the depth of information that could be collected and analyzed. As a result of the limited time there was also a limited scope based on geographical location. The area the surveys were conducted may have a broader array of complimentary alternative modalities than other communities. The sample used was limited to practitioner's either known to work with childhood trauma or those who advertised working with childhood trauma.

CONCLUSION

In conclusion, childhood trauma impacts many people. The child is affected, and the implications of the trauma often continue into adulthood, which then has far reaching consequences for society as a whole. This research reflects that childhood trauma is very complex and difficult to treat and that effective treatment involves both the mind and body. Multiple treatment approaches that access both the left and right side of the brain seem to be more effective than an individual treatment modality. The use of complimentary alternative modalities along with traditional treatments would appear to provide more promising results. Further study of childhood trauma treatments for patients and practitioners is needed.

RECOMMENDATIONS

Recommendation for further research would be to conduct studies that look at:

1. Further study on PTSD in children (most current studies of PTSD are of veterans).

2. Study effectiveness of interventions for children with PTSD.

3. Integrate existing knowledge of neurological studies of PTSD into treatment methodology.

4. Further research on the effectiveness of medications for the treatment of childhood trauma.

5. Further research on interventions and early post-childhood trauma treatments.

6. Further research on childhood trauma prevention.

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APPENDICES

Appendix A: survey
Appendix B: interview questions
Appendix C: treatment modality chart
Appendix D: definitions of treatment modalities
Appendix E: graph of EMDR effectiveness

Appendix B
Research Questionnaire
"Treatment of Childhood Trauma"

1. What specialized training have you received to prepare you for working in the area of childhood trauma?

_____
_____
_____
_____
_____

2. What improvements would you like to see in the treatment of childhood trauma?

_____
_____
_____
_____
_____

3. What cultural differences are important to consider when treating childhood trauma?

_____
_____
_____
_____
_____

4. Do you have any recommendation or suggestions of special training for those interested in treating childhood trauma?

_____
_____
_____
_____
_____

5. Please describe any Complimentary Alternative Modality that you use and talk about the effectiveness and use of that modality.

_____
_____
_____
_____
_____

Appendix C
Intervention Effectiveness Ratings of Treatment Modalities

Interventions	N	Mean	Standard Deviation
Other	11	4.36	.809
Family Therapy	24	4.25	.847
Group Therapy	23	4.17	.984
Individual Therapy	26	4.12	.766
Art Therapy	19	4.00	.745
CBT	28	3.89	1.031
Play Therapy	19	3.74	.872
Meditation	18	3.67	1.029
SE	14	3.29	.914
Medication	23	3.17	1.072
Music	15	3.13	1.246
EMDR	11	3.00	1.414

Appendix D

Definitions of Treatment Modalities

Except where noted the following definitions are from (Encyclopedia of Psychotherapy, 2002).

- Art therapy- "utilizes art media and images, the creative process, and client responses to art productions as reflections of individual's development abilities, personality interests, concerns and conflicts" (Vol. 1, p. 113).

* Cognitive behavioral therapy (CBT) –"incorporates principles associated with information processing and learning theories. A basic assumption of CBT is the recognition that there is a reciprocal relationship between the clients' cognitive processes (what they think) and their affect (emotional experience), physiology and behavior" (Vol. 1, p. 451).

- Eye Movement Desensitization and Reprocessing (EMDR) - "Is an eight-phase treatment approach that facilitates resolution of distressing historical events, desensitization of present triggering stimuli, and acquisition of desired behaviors. EMDR is used within a comprehensive treatment plan to address a range of experientially based complaints" (Vol. 1, p.777).

* Group therapy- "several people meeting together, and is used as a treatment modality to address psychological issues especially those involving unsatisfactory interpersonal skills" (Vol. 1, p.892).

* Family therapy- "is a perspective of interpreting and modifying behavior, a perspective implemented as a model of psychotherapy with the family" (Vol. 1, p. 793).
* Individual therapy- "individual treatment of mental disorders and behavioral disturbances using verbal and non verbal communication." (Vol. 2.p. 7).

* Medication therapy- "the act or process of treating with medicine" (American Heritage Medical Dictionary Copyright 2007).

- Meditation therapy- "a practice of quietly listening and noticing…it slows the mind and internally releases the pressure that may have appeared to come from the circumstances or problems of life" (Learn Meditation; Meditation Manual, http://users.erols.com/peterbb/meditman.htm, ch. 9, pp 1, 2008)".

- Music therapy- a treatment in psychotherapy in which the client uses sound and or music as part of therapy.

- Somatic Experiencing (SE)-"Is learning to define trauma by its symptoms, rather than by the event, we can develop perspectives that will help us recognize trauma when it occurs" (Levine 1997, p.152).

    * Represents traditional modalities
    - Represents complimentary alternative modalities