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# Families Healing Together: A Multi-family Group Curriculum Proposal

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## Abstract

This paper presents evidence that supports the need to create and implement a trauma-focused multi-family group curriculum. The introduction provides a broad definition of post-traumatic stress disorder (PTSD) as well as a definition of complex trauma. The paper also reviews research for trauma-specific evidence-based interventions for individual, group, and multi-family group psychotherapy. A curriculum that involves multi-family support, family therapy, age-specific group treatment, and individual therapy is presented. In addition, limitations and future and multicultural considerations are discussed.



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# Families Healing Together: A Multi-Family Group Curriculum Proposal

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## Abstract

This paper presents evidence that supports the need to create and implement a trauma-focused multi-family group curriculum. The introduction provides a broad definition of post-traumatic stress disorder (PTSD) as well as a definition of complex trauma. The paper also reviews research for trauma-specific evidence-based interventions for individual, group, and multi-family group psychotherapy. A curriculum that involves multi-family support, family therapy, age-specific group treatment, and individual therapy is presented. In addition, limitations and future and multicultural considerations are discussed.

# Literature Review

## Defining PTSD and Complex Trauma

PTSD is defined as a "psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent assault" (American Psychiatric Association, 2020, para. 1). Within the disorder, certain populations develop symptoms from a multitude of traumatic events and whose traumatic stress can be a result of years of generational and multi-event traumatic experiences. To address such symptoms, interventions geared towards addressing trauma from a complex trauma lens are useful. Complex trauma in childhood is defined by The National Traumatic Stress Network as:

> Both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability (Peterson, 2018, para. 1).

While there are many treatment interventions for PTSD that are empirically validated, the need for intensive treatments for children and families who experience complex trauma remains.

## Evidence-Based Treatment

Several evidence-based approaches have been developed to address symptoms of PTSD. Prolonged exposure is a treatment designed to confront fear cues by creating a list of stimuli via

an exposure hierarchy (moderate to severe) of environmental triggers such as places, sounds, or people that the brain associates with fear or anxiety (Foa, Hembree, & Rothbaum, 2007). Within prolonged exposure, interventions are broken down into two categories: imaginal exposure and in vivo exposure. Imaginal exposure focuses on reliving the traumatic scene within the imagination. The client is asked to describe the scene or event aloud in the present tense several times during sessions with their therapist. Over time, the therapist asks the client to focus on and describe their psychological response to the event. The descriptions are then recorded so the client can listen to the events between sessions for increased exposure. Alternatively, in vivo exposure places the client directly in the feared situation by exposing them to the environmental stressor in a real-life circumstance (e.g., if a client is afraid to go to the grocery store, a therapist will accompany them there and help them work through the fear response in the moment) (Monson, Resick, & Rizvi, 2014).

Another evidence-based intervention commonly used for treating PTSD is Cognitive Processing Therapy (CPT) (Resick, Monson, & Chard, 2017). First developed as an effective treatment for symptom reduction in sexual assault survivors, CPT is now more generalized to work in reducing symptoms for a wide range of psychological symptoms among different populations (Resick et al., 2007). It has been used in both individual and group formats that integrate written forms of exposure. This structured intervention requires the client to develop an impact statement, which identifies how severe traumatic events have impacted the client's view of themselves and others. As the client reads the statement aloud, they are asked to focus on any distorted thoughts that arise, with an emphasis on self-blame. Most commonly, clients present with thought distortions relating to their behaviors (e.g., that they could have stopped the event), or that the trauma was deserved or warranted. Trauma processing in CPT begins when a client

effectively learns to label their emotions and make conclusions regarding the impact of their distorted thoughts in relation to the event and subsequent feelings and behaviors (Monson, et al., 2014). Numerous studies also support treatment that combines cognitive-behavioral therapy (CBT) interventions with other forms of prolonged exposure. This form of treatment integrates techniques from CBT (e.g., challenging problematic thinking, relaxation strategies, coping skills) with the practices of imaginal, in vivo, and written exposure (Monson et al., 2014). Specific treatments that integrate components of CBT are discussed in later sections.

Skills Training in Affective Interpersonal Regulation (STAIR) is a phase-based approach to treatment that targets symptoms specific to child sexual abuse where affect regulation and interpersonal effectiveness are highly impacted areas beyond presenting symptoms of PTSD. The treatment prioritizes the stabilization of those symptoms prior to asking the client to try a modified version of imaginal exposure (Monson et al., 2014). It's composed of eight modules that cover the following goals and objectives: understanding the impact of trauma on emotions and relationships, improving emotional awareness, increasing coping skills, and developing affirming ideas and feelings about self and others to improve interpersonal functioning (Cloitre, Koenen, Cohen, & Han, 2002).

Herman (1992) developed a stage-oriented model that proposes three steps to treatment: safety and stabilization, remembrance and mourning, and reconnection and integration. In the first step, safety and stabilization, the therapist and client establish an alliance and work on the development of healthy boundaries. In this phase of treatment, the following objectives are covered: the treatment plan, safety, emotion identification and expression, recognizing adaptive and maladaptive behaviors, self-care, establishing empowerment and self-compassion, and increasing knowledge and use of coping skills. In phase two, remembrance and mourning, the

therapist works with the client to assess traumatic memories, acknowledge the impact of the traumatic event(s), and create a safe space to mourn losses related to the trauma. Stage three, reconnection and integration, is focused on hope, establishing goals for the future, and releasing control the trauma had.

Another widely known phase-based approach treatment modality is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2012). TF-CBT is a short-term, evidence-based model that serves children and families by combining CBT skills in a way that is sensitive to the impacts of trauma on a child and the child's family system. Treatment is manualized and broken down into the following modules: psychoeducation and parenting, cognitive coping, trauma narrative development and processing, in vivo exposure, conjoint sessions with parent and child, enhancing safety, and future development. Treatment often lasts between eight and 16 sessions and includes individual therapy for the child, parent support sessions, and dyadic (e.g., parent/caregiver and child) or family sessions towards the conclusion of treatment (Pleines, 2019).

**Group Therapy**

Sloan, Beck, and Sawyer (2017) proposed three types of group therapy models that are effective in the treatment of trauma: support groups, CBT groups, and psychodynamic or interpersonal groups. Support groups are often unstructured and conducted in an open format, meaning that group members are welcome to join and leave the group at any time. These can be led by trained or untrained individuals. The central focus is to cultivate an environment of acceptance (Yalom, 1995). In contrast, CBT groups have a closed format, are structured, time-limited, and are typically led by a trained therapist. The focus of CBT groups is on skill building, including the development of an individualized treatment plan for each group member.

Depending on group goals in relation to trauma symptoms, the CBT groups tend to address "extinction, dysfunctional cognitions, anger, social isolation, and other facets of PTSD" (Sloan, Beck, & Sawyer, 2017, p. 468). Psychodynamic and/or interpersonal group therapy focuses on how trauma has affected an individual's perception of themselves, others, and the world (Sharpe, Selley, Low, & Hall, 2001). It involves a client-centered approach, as the pace of the group is determined by its members and focuses less on following a predetermined agenda or curriculum. Groups with an interpersonal focus tend to emphasize ruptures in relational functioning after a trauma has occurred (Markowitz et al., 2015). The groups are commonly closed and are led by trained therapists (Sloan et al., 2017).

**Trauma Group Therapy Curriculums**

Chard (2005) developed a curriculum that addressed issues related to trauma processing within a group setting (e.g., resistance to recounting trauma in front of others, triggering other members, and limiting time for processing) while emphasizing the importance of social support. The group is structured to incorporate 17 weekly CPT group sessions along with 10 individual sessions that occur simultaneously. Individual sessions aim to develop and process trauma impact statements while also challenging trauma-related cognitive distortions, whereas group sessions are used to practice skills. Individuals that participated in this group showed a reduction in symptom severity and were less likely to drop out of treatment when compared to individual trauma-focused treatments (Imel, Laska, & Jakupcak, 2013).

Trauma Management Therapy (TMT) (Frueh, Turner, Beidel, Mirabella, & Jones, 1996) is another group curriculum that focuses on improving trauma symptoms and interpersonal functioning. TMT involves a phase-based approach, and similar to Chard (2005), it combines both a group and an individual format. However, TMT works on reducing feared stimuli through

exposure-based interventions in individual therapy and then conducts group sessions later that build on these skills. Studies noted that while symptom reduction was observed in the participants, the dropout rates were higher when compared to individual exposure-based treatments (Sloan et al., 2017).

Another treatment modality that combined group and individual treatment was developed by Smith et al. (2015). The treatment lasts 12 weeks and includes weekly group therapy and individual therapy, which begins halfway through treatment. Similar to other combination treatments, the group therapy sessions are designated for skill-building and psychoeducation while the individual sessions are used for imaginal exposure. Once again, a reduction in symptom severity was observed; however, the dropout rate appeared similar to other group and individual treatments.

Ready et al. (2008) developed Group-Based Exposure Therapy (GBET) and proposed that trauma processing can occur within the group setting. Previous treatments for trauma focused on processing trauma in an individual format, and emphasized skill-building in the group format. Their treatment, which involves participants taking turns verbally recounting their trauma, takes place twice a week with each session lasting three hours. Treatment is broken down into three phases: stress management, exposure, and relapse prevention. They propose two components that make group trauma processing safe and therapeutic: emphasizing group cohesion at the onset and leaving enough time per session to process what participants have shared. The authors reported that GBET was first piloted on 102 veterans with a small dropout rate of only three participants.

**The Traumatized Family**

Over time, research has supported the use of trauma-informed interventions to reduce symptom severity for individuals impacted by trauma. Cloitre et al. (2009) noted that the impact of trauma, in particular complex trauma, is multi-dimensional and creates ruptures in attachment, development, affect regulation, coping, and how one views the world. They commented that "treatment for these disorders would seek to heal attachment-related injuries, to rehabilitate developmental competencies, and to revise ongoing emotional reactivity, maladaptive interpersonal patterns, and negative social perceptions" (Cloitre et al., 2009, p. 395). Historically, services have aimed to reduce symptoms of PTSD and have neglected to address the implications of childhood complex trauma on the entire family system (Van der Kolk, 2014). Figley and Kiser (2013) suggested the idea of "systemic dysfunction," (p. 6) which refers to a ripple effect that happens when one family is impacted by a traumatic event. They proposed that a family's ability to heal and recover from trauma is significantly impacted by "the context of the current set of stressors, the family perception of stressors, and the healing resources of the family" (Figley & Kiser, 2013, p. 36). Therefore, they emphasized that interventions should include not only the traumatized individual but the entire family system as a way for the system to heal as a whole.

**Multi-Family Groups**

Dr. Peter Laquer developed Multi-Family Group Therapy (MFGT) in the 1950s. According to Howe (1994), this intervention involves working with:

> A collection of families, including the family's identified patient, in a group setting. It combines the power of group process with the system's focus of family therapy. MFGT is ideally suited to working with families facing similar problems (e.g., schizophrenia,

> chemical dependence, domestic violence, sexual abuse, having a child in out-of-home placement, etc.) (para. 1).

It was first developed to improve treatment and recovery for patients diagnosed with a schizophrenia spectrum diagnosis in inpatient hospitals and has since been used for the treatment of substance use disorders, serious and persistent mental illness, domestic violence and sexual assault recovery (Howe, 1994); however, limited information and current research exists on the implementation and efficacy of this specific treatment (Edwards & Prouty, 2001).

Strengthening Family Coping Resources (SFCR) is a curriculum developed by Kiser (2006) that implements treatment for the traumatized individual and their family within a group therapy treatment modality. The service is broken down into three modules, with each session offering an opening and a closing ritual that integrates a group self-regulation exercise or giving gratitude. Each session also offers a meal for families and facilitators to enjoy together. The first module includes three two-hour sessions that introduce activities to enhance familial cohesiveness and connection such as telling family stories and putting together a family ritual tree. The second module is comprised of six sessions that introduce coping strategies to increase safety and stabilization. In this module, families work on building their support network, creating family activities, and defining their spirituality. The family's trauma history is introduced in the third module, over the final six sessions. Drawing upon the coping skills developed in the second module, families work together with facilitators to put together a trauma narrative. The last session is reserved for recognizing treatment completion with a celebration (Kiser, Donohue, Hodgkinson, Medoff, & Black, 2010). Results of a pre and post-design research trial demonstrated the possible positive outcomes of SFCR. Kiser et al. (2010) noted that "participant completion rates, attendance, and intervention satisfaction provide evidence of the acceptability

and tolerability for low-income, urban families" and that "this finding is important considering the daily hassles, multiple environmental stressors, and chronic trauma that often interferes with treatment completion" (p. 805).

## Curriculum Proposal

### Statement of Problem

Given the extensive research disseminated in the literature review that supports phase-based approaches to trauma-informed care and the continued effort by practitioners to involve a client's family system into the treatment model, the curriculum outlined in this doctoral paper proposes the implementation of a multi-family group therapy model that integrates evidence-based practices with group therapy treatment recommendations to deliver an effective treatment modality that involves the client's family. In contrast to the curriculum developed by Kiser (2015), this curriculum introduces client-centered approaches to treatment as well as focused breakout sessions that offer support and intervention to family members based on age (e.g., child, adolescent, and adult or caregiver interventions). The client-centered approach is reflected in the phases that allow the family and/or client to decide whether the trauma processing component of treatment should be done with the family or with the individual depending on the nature and severity of the trauma and/or the comfort level of the impacted individual. Furthermore, in contrast to SFCR, trauma processing is only conducted in family or individual sessions with an assigned family therapist in order to protect the vulnerability of developing a trauma narrative. While previous research supports that group trauma processing can be effective, the existing findings are mostly restricted to veteran populations and there is limited research supporting that group trauma processing would be beneficial for children or families who have faced a broad range of traumatic events (Sloan et al., 2017). Therefore, a treatment curriculum that focuses on

complex trauma for the individual and family in a multi-family group setting will offer the opportunity for healing and recovery via a structured, time-specific, intensive outpatient intervention for treating traumatized children and their families.

**Curriculum Development**

Families Healing Together (FHT) was modeled from a phase-based treatment approach developed and adapted by Reaching HOPE, a non-profit agency located in Commerce City, Colorado. Reaching HOPE is an agency that provides mental health services to those impacted by child abuse, sexual assault, relationship violence, and other traumatic events (Reaching HOPE, 2020). Their model aligns closely with the work of Judith Herman (1992) while also integrating a family systems approach to treatment. The agency provides services to the entire family by assigning an individual therapist to each family member and asking that the whole family, availability permitting, join treatment at the same time. Their phase-based approach occurs in four stages: family and environmental safety and stabilization, internal safety and stabilization, trauma processing, and building resiliency and social engagement. Drawing upon the work of Judith Herman (1992) and the model developed by Reaching HOPE, the curriculum proposal detailed below will be segmented into similar phases, integrating techniques and approaches from a multitude of empirically supported treatment modalities, reputable clinical resources, and personal experience working with traumatized populations in various settings.

## Summary

**Recruitment**

Individuals will be recruited through Reaching HOPE's referral system. A majority of Reaching HOPE's client base is referred from Ralston House, a child advocacy center that investigates child abuse and connects victims to services, after a child has gone through a

forensic interview to document any disclosures of abuse or neglect. Participants will be pulled from the agency's already existing client base who have completed the intake process and were screened for group appropriateness. Screening procedures should take the following areas of consideration into account: family size, age of victim and siblings (e.g., appropriateness will be measured by language fluency and level of comprehension), engagement and commitment to treatment, acuity of symptoms (e.g., clients or family members with serious and persistent mental disorders, substance use disorders, or intellectual disability are not recommended), and limited externalized behaviors (e.g., clients who often engage in aggressive, harmful, or destructive behaviors are not recommended). Facilitators should also anticipate enough participants per age-specific group (e.g., a minimum of three participants for the child, adolescent, and adult groups). Lastly, perpetrators will not be permitted access to treatment.

**Intake Procedures**

Once families are screened for group appropriateness, they will attend an intake session with their assigned family therapist to review group guidelines, confidentiality, and sign a commitment to treatment document that reviews the group curriculum, dates of services, and time commitment. In order to start treatment, families must agree to attend the group for the full 12 weeks; however, there will be an exception for unforeseen circumstances, allowing one excused absence per family. More than one absence will result in dismissal from the multi-family group.

**Structure**

FHT is a structured, closed-format, 12-week intensive outpatient multi-family group treatment. Each week will last two hours, and the format will vary based on the weekly curriculum objectives (e.g., multi-family group, family therapy, age-specific group, and

individual therapy if needed). The group will have 15 to 20 participants (five families maximum) and one facilitator will be assigned to each family (five facilitators maximum). A detailed description of the format and content of each session can be found in the provider manual (Appendix A) and a brief overview of the content is provided within the following section.

**Phase one**. Phase one, family and environmental safety and stabilization, is comprised of three sessions that are broken down into two parts. Part one, week one, has a multi-family group format and focuses on the following objectives: verbal acknowledgment of group privacy, introductions, review of the curriculum, establishing group rules, and providing psychoeducation on recognizing abuse. Part two, week one, has a family therapy format with individual family therapists that will be assigned at intake. The objectives focus on developing individualized safety plans and establishing familial household rules and expectations along with healthy consequences and rewards. The second week of phase one begins with the multi-family group format and covers the psychosocial impacts of trauma. Part two is spent in the family therapy format developing a family genogram. Week three of phase one begins with the multi-family group format and reviews boundary development followed by part two which is spent with individual family therapists discussing boundaries within the family.

**Phase two.** Phase two, internal safety and stabilization, begins during the fourth week. It is also comprised of three sessions that are broken down into two parts. Part one, week four, starts with the multi-family group format and the objectives cover the impacts of trauma on the brain and body, identifying individual family triggers, and facilitation of a group relaxation exercise. Part two of week four introduces age-specific groups (child, adolescent, and adult) and participants are instructed to split up into three separate rooms with assigned facilitators. Broadly, the objectives for each age-specific group review emotion identification and introduce

mindfulness, grounding, and containment strategies. Week five of phase two begins with the multi-family group format and introduces concepts related to the importance of enhancing health and well-being (e.g., self-care, sleep hygiene, and behavioral activation). Part two continues with the age-specific groups and covers the development and implementation of coping strategies. Week six begins with the multi-family group format and starts by reviewing coping skills followed by an introduction to negative thought patterns and a discussion around empowerment and self-compassion. The age-specific groups this week cover challenging negative thought patterns and practicing positive affirmations.

**Phase three.** Phase three, trauma processing, begins week seven and lasts through week 10. Week seven maintains the multi-family group format and reviews the impacts of trauma on the family and acknowledges family strengths. During part two of week seven, family therapy resumes, and individual family therapists review and update family safety plans, develop a hierarchy of stressors, and complete a self-care plan to be followed after the session is complete. Week eight is spent with individual family therapists for the duration of the session (two hours) and during that time families and their assigned therapist review and process trauma avoidance, review the family safety plan, create a family impact statement, and continue the development of a self-care plan. The format for weeks nine and 10 will depend on the facilitator's assessment of client readiness and the client's input on readiness to begin developing a trauma narrative. If the family or individual who experienced the trauma is not ready to move forward with developing a trauma narrative, family therapists can use the full two-hour session to review skills from prior sessions. Additionally, weeks nine and 10 can be spent developing a trauma narrative with the family present or in individual sessions.

**Phase four.** Phase four, building resiliency and social engagement, begins week 11. Part one of week 11 is spent in the multi-family group format and the objectives focus on understanding the warning signs of future abuse and an introduction to post-traumatic growth. Part two is spent with individual family therapists in separate rooms reviewing areas of growth and resiliency. The final week is a multi-family group for the duration of the session (two hours). It includes a celebration of the family's accomplishments where dinner is provided, families review goals for the future, and a certificate of completion is presented.

## Discussion

FHT is a composition of reputable evidence-based practices pulled together by this writer. The intention behind the development of this project is to present an array of literature that provides a wide breadth of knowledge of a multitude of clinical interventions for the treatment and prevention of childhood complex trauma. While the creation of a comprehensive multi-family group treatment modality proved challenging, it highlighted the need for increased intervention for children and families generationally impacted by trauma. The curriculum presented in this doctoral paper includes a dive into robust research, online resources, consultation with experts in the field, and professional experiences that intend to lay the foundation for clinicians to help clients heal from trauma in a meaningful and effective way.

### Multicultural Considerations

Reaching HOPE primarily serves clients in the Commerce City area which is represented by 47.4 percent Hispanic or Latinx individuals and 43.6 percent White individuals (U.S. Census Bureau, 2019). Given the diversity of the population being served, Reaching HOPE fully recognizes its limitations in implementing a curriculum that is both linguistically and culturally representative and sensitive. While the current state of FHT is best suited for English speaking

clients, future implementation will consider collaboration and consultation with bi-lingual/bi-cultural therapists to translate the curriculum into Spanish and ensure that cultural meaning and relevance is maintained. Further, the following multicultural standards should also be considered and implemented before starting FHT. Anderson (2010) defines multicultural group work as:

> A helping process that includes screening, assessing, and diagnosing dynamics of group social systems, members, and leadership for the purpose of establishing goals, outcomes, process, and interventions that are informed by multicultural counseling, knowledge, skills, and abilities. It is a process of planning, implementing, and evaluating group work strategies from a socio-cultural context of human variability, group, and individual identity, worldviews, statuses, power, and other salient demographic factors to facilitate human and organizational development. The goal of multicultural group work is to promote human development and to enhance interpersonal relationships, promote task achievement, and prevent or identify and remediate mental, emotional, or behavioral disorders and associated distress that interfere with mental health, and to lessen the risk of distress, disability, or loss of human dignity, autonomy, and freedom (pp. 225-226).

There are steps facilitators should take upon screening, assessment, and intervention that establish fidelity with competent multicultural group work. Anderson (2010) discusses a multicultural group work design that considers the following variables upon engaging in group treatment: clinical presentation, evidence-based care, group composition, mental health status including strengths and weaknesses, and unique member characteristics (e.g., culture, worldview, identities, statuses, and power) in order to conceptualize the appropriate group dynamic that should take place. Subsequently, there should be extended conversations related to cultural

identity, cultural explanations of presenting concerns, cultural factors that may be contributing to environmental stressors and overall functioning, and therapeutic alliance/power differentials.

In addition, other variables that may impact structure, dialogue, and process are the multicultural competence of the facilitators, the composition of the group with regard to clinical presentation and social identities, and the presence of balance between privileged and non-privileged participants. Given the context of complex trauma and the high impact of symptoms across the lifespan, it will be important for facilitators to find a therapeutic balance between addressing clinical presentation (e.g., trauma symptoms) and acknowledging, honoring, and affirming all identities in the room (e.g., culture and/or ethnic identity, religious affiliation and/or spirituality, sexual orientation, gender, age, etc.). The goal, in this respect, will be to hold space for exploration and to keep multicultural dimensions in conscious awareness. In order to do so, facilitators should pursue the following steps to acquire a baseline for maintaining consciousness of group dynamics from a multicultural lens: an exploration of personal experiences, biases, and blind spots through peer supervision and consultation, staying up-to-date on relevant research and training and seeking external consultation from professionals who specialize in working with certain populations. As such, facilitators will avoid the probability of causing significant harm should variability be ignored; thus, creating a growth-enhancing group environment that values and respects group differences (Anderson, 2010).

**Limitations and Future Considerations**

Implementing a multi-family group should anticipate certain limitations concerning recruitment, funding, and participation. Recruiting families that are able and willing to commit two hours a week for 12 weeks will have its challenges. Further, given the structured and time-limited nature of the group, certain families who are unable to attend each session may be at risk

of falling behind on the curriculum. In this case, facilitators should be flexible in setting up alternate dates to review materials prior to the following session. In addition, age-specific group sessions can run with one or two members if needed and the interventions may be adjusted accordingly; however, given the extra commitment this scenario may place on providers, group members must commit to attending each session, barring extenuating circumstances.

In order for the group to be most effective, sufficient funds will need to be discussed around access to facilities, resources, and materials. Reaching HOPE uses crime victim's compensation funding to pay for services; however, this funding is limited and will be prioritized for individual and family work. In the future, grant funding using this curriculum proposal will be used to acquire the appropriate space and materials to start the group. The multi-family group curriculum was intended for piloting in the Spring of 2020 at Reaching HOPE. Due to unforeseen circumstances, it was decided that the project would move forward without integrating implementation and feedback from providers. Certain limitations, such as funding, prevented the agency from moving forward with the pilot. In addition, the shift to telehealth with increased safety concerns centered around the COVID-19 global pandemic would have greatly limited the agency's ability to implement this curriculum.

In the future, the curriculum will be instituted at Reaching HOPE or a rented space and facilitated by licensed psychologists or doctoral psychology candidates with a background in trauma. Upon implementation each phase will be delivered and critiqued based on feasibility, clarity of instructions, time management, funding, and applicability. Facilitators should also consider during the implementation phase, whether family and individual treatment goals should be modified based on symptom presentation and acuity and the addition of tailored homework assignments can be added weekly, preferably by individual family therapists, to increase skill

mastery. Following treatment, participants and their families are encouraged to continue treatment at Reaching HOPE if needs related to safety, stability, and trauma processing remain. After the initial implementation phase, Reaching HOPE will outreach community mental health centers, schools, and organizations that represent minority populations throughout Adams County to broaden opportunities for recruitment and ensure underrepresented groups have access to FHT.

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Appendix A

Provider Manual

**Families Healing Together**

**Provider Manual**

This manual outlines the 12-session curriculum divided by phases and weeks.

The activities discussed in the manual are numbered and corresponding links can be found in the resources section of this document (Appendix B).

**Phase 1: Family and Environmental Safety and Stabilization**
**WEEK 1:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:
- Review privacy with other group members
- Introductions
- Ice breaker
- Establishing group rules
- Review of Multi-Family Group curriculum
- Psychoeducation on recognizing abuse

**Activities**:
- Review limits of confidentiality and discuss privacy of fellow group members within the multi-family group format
  - Request a verbal commitment from each family to maintain confidentiality within the group setting
  - Openly discuss possibilities for contact outside of the group format (e.g., members initiating contact with each other, possibility of attendance at the same school for children, etc.)
- Introductions/Ice Breaker:
  - Each family/family members will be asked to introduce themselves by their preferred name, age, and pronoun
  - Separately, families will be asked to work together in drawing a picture of their family and family members
  - Upon returning to the larger group format, families will take turns sharing their drawing, identifying each family member and describing salient aspects of each family member (e.g., culture and/or ethnic identity, religious affiliation and/or spirituality, personal interests or hobbies, personality characteristics, interesting or unique facts, etc.)
- Together, the group members will generate a list of appropriate group rules, which are to be recorded by the group facilitator. If possible, the facilitator will write the rules on a large piece of paper or white board that is visible to the group
  - This activity is primarily led by participants with the help of facilitators
- Provide each family with the curriculum hand out for participants, while delivering an overview of the group content
- Using The Power and Control Wheel *(1),* begin psychoeducation on recognizing abuse

**Materials**:
- Tables and chairs
- Poster
- Construction paper
- Colored pencils or markers
- Curriculum outline handout

- Power and Control Wheel handout

**Set-Up**:
- Table and chairs for each family/family members
- Construction paper and markers and/or colored pencils at each table

***Break/Transition (10 minutes)***

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**Phase 1: Family and Environmental Safety and Stabilization**
**WEEK 1:** Part 2

**Length**: 50 minutes
**Format**: Family Therapy

**Objectives**:
- Develop a safety plan
- Establish household rules and expectations
- Establish healthy consequences and rewards

**Activities**:
- Assess family safety using the following prompts for guidance:
  - What are the individual and family triggers?
  - What are common responses to individual and family triggers?
  - What are some coping skills the family can engage in?
  - What are some ways to make the environment safer?
- Using a poster board, outline household rules and expectations
- Using a poster board, outline healthy consequences and rewards (define the concepts of consequences and rewards, if necessary)

**Materials**:
- Poster board
- Colored pencils and/or markers

**Phase 1: Family and Environmental Safety and Stabilization**
**WEEK 2:** PART 1

**Length:** 60 minutes
**Format:** Multi-Family Group Therapy

**Objectives**:
- Psychosocial impacts of trauma

**Activities**:
- Review Impacts of Trauma worksheet from echo *(2)*

- Individually, families work with therapists stationed at tables to assess reactions to the Impacts of Trauma worksheet
  - Families are encouraged to expand on the information provided in the handout, if applicable. However, it is recommended that specifics of trauma history are not explicitly discussed during this activity

**Materials**:
- ❖ Tables and chairs
- ❖ Impacts of Trauma handout
- ❖ Paper and Pens

**Set-Up**:
- ❖ Table and chairs for each family/family members
- ❖ Blank sheet of paper with pens provided on each table

***Break/Transition (10 minutes)***

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**Phase 1: Family and Environmental Safety and Stabilization**
**WEEK 2:** PART 2

**Length**: 50 minutes
**Format**: Family Therapy

**Objectives**:
- ❖ Develop a family genogram

**Activity**:
- ❖ Using a large poster board, family therapists will follow a key from Therapist Aid *(3)* as a basic guideline for creating the family genogram
  - If the therapist has limited experience in creating genograms, it is recommended that they seek consultation, supervision, or training prior to the session
  - Once the genogram is complete, the therapist will engage the family in a series of questions to process the genogram. Sample questions may include:
    - How did you feel while completing the genogram?
    - What came up for you and your family?
    - Are there any patterns that stand out to you?
    - Did you learn something new?
    - How does this contribute to your understanding of trauma?

**Materials**:
- ❖ Poster board
- ❖ Colored pencils and/or markers

**Phase 1: Family and Environmental Safety and Stabilization**
**WEEK 3:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:

- Boundary development

**Activities**:

- Begin the session by facilitating a discussion around boundary development using the following prompts as a guideline:
  - What is a boundary?
  - What do healthy boundaries look like?
  - What are ways to communicate boundaries? Examples:
    - I have a problem with that…
    - I don't want to…
    - I've decided not to…
    - This is what I need…
    - This is hard for me to say…
    - I understand your point of view, but, …
    - I feel uncomfortable about…
    - I would rather not…
    - Yes, I do mind…
    - I would prefer not to…
    - It's important to me…
    - I'll think about it…
    - That's unacceptable…
    - I guess we see it differently…
  - Who do you need to be establishing boundaries with?
- After the discussion, break up into groups with individual family therapists and develop a safety circle using the following instructions as a guideline:
  - Draw a circle on a large piece of paper
  - Have the family fill the middle of the circle with people they deem as safe or people they would turn to for support
  - On the edge of the circle have the family write names of people they consider acquaintances, but wouldn't share personal details with
  - Reserve the outside of the circle for people that the family deems unsafe
- Come back together as a group and process the experience using the following prompts as a guideline for the discussion:
  - How difficult was it to think of people who are supportive and safe?
  - Is it important to use boundaries with certain people over others?
  - What do boundaries look like for safe people?
  - What do boundaries look like for unsafe people?

**Materials**:

- Table and Chairs
- Blank sheets of paper
- Colored pencils and/or markers

**Set-Up**:

- Table and chairs for each family/family members
- Blank sheet of paper with colored pencils and/or markers on each table

***Break/Transition (10 minutes)***

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**Phase 1: Family and Environmental Safety and Stabilization**
**WEEK 3:** Part 2

**Length**: 50 minutes
**Format**: Family Therapy

**Objectives**:

- Practicing boundary development

**Activities**:

- Family therapist will lead family in a boundary awareness exercise using the following instructions as a guideline:
  - To begin, the therapist will demonstrate how the game is played by volunteering to go first
  - The therapist stands on one side of the room and has one family member stand on the opposite side of the room
  - The therapist instructs the family member to ask the therapist if they can take a step closer to them
  - The therapist demonstrates their boundaries by responding *"yes, you can take a step closer"* or *"no, you cannot come any closer"*
  - Once the therapist says *"no, you cannot come any closer"* they are demonstrating their boundary with that person in terms of space
  - After the demonstration, each family member has a turn being both the person who asks to take a step closer and the person who responds *yes* or *no*
  - To demonstrate how boundaries may look different between family members and providers, the therapist will take a turn with each family member, modeling the importance of maintaining appropriate boundaries with individuals outside of their family
- Once everyone has taken a turn, process the activity with the family using the following questions as guidance for discussion:
  - Why did you let one family member come closer than the other?
  - Are there times you want your family members close and times you want more space?
  - How do you communicate when you want more space?
  - How do you communicate when you want to feel closer to family members?
  - How do you respond when a family member asks for space?

**Materials**:

- No materials needed

**Phase 2: Internal Safety and Stabilization**
**WEEK 4:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:
- The impact of trauma on the brain and body
- Identifying individual and family triggers
- Relaxation exercise

**Activities**:
- Begin the session by reviewing a handout on how trauma impacts the brain using the Stress and Early Brain Growth: Understanding Adverse Childhood Experiences (ACEs) handout *(4)*
- Review states of hyper-arousal and hypo-arousal and the window of tolerance using a handout from The National Institute for the Clinical Application of Behavioral Medicine *(5)*
- After a brief group discussion on the impacts of trauma, have the families meet with their family therapists in separate rooms to write out individual and family triggers on a blank sheet of paper
- End the session by rejoining as a group and leading everyone through a progressive muscle relaxation exercise from Therapist Aid *(6)*

**Materials**:
- The impact of trauma on the brain and body handouts
- Table and Chairs
- Blank sheets of paper
- Colored pencils and/or markers

**Set-Up**:
- Table and chairs for each family/family members
- Blank sheet of paper with colored pencils and/or markers on each table

***Break/Transition (10 minutes)***

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**Phase 2: Internal Safety and Stabilization**
**WEEK 4:** Part 2

**Length**: 50 minutes
**Format**: Group Therapy by Age

**Objectives**:
- Emotion identification
- Introduction to mindfulness, grounding, and containment strategies

**Activities by Age Group:**

**Child Group**

- Present the Emotions Wheel handout *(7)* to participants
- Give the participants 15-20 minutes to fill in the emotions wheel using the following instructions as a guideline:
    - Spaces can be filled with colors, pictures, or symbols that represent each emotion for the participant
    - After filling out the wheel, rank each emotion from the most experienced emotion to the least experienced emotion
    - Have each child go around and share what they colored in or what they drew for their strongest emotion along with a story describing when they experienced their strongest emotion
- Conclude the group session by leading the participants in a mindfulness scavenger hunt. Provide each child with a brown paper bag and allow them to search around the room for items that activate their five senses (e.g., touch, smell, sound, taste, and hearing)

**Adolescent Group**

- The adolescent group will also complete the emotions wheel exercise using the same instructions from the child group
- When the emotions wheel exercise is complete, the session will conclude with silent journaling using the following prompts to engage the participants in a moment of mindfulness:
    - What is happening now?
    - Where is your awareness most focused now?
    - What do you notice now?
    - What are you curious about right now?
    - Notice the thoughts that are passing by, what are they saying?
    - Noticing the sensations in your body right now, what do you feel?
    - Where in your body do you feel this emotion?
    - Paying attention to your breathing, what do you notice?
    - With kindness and curiosity, what choices can you make?
    - What can you let go of?
    - What story are you telling yourself right now?
    - What label or judgment are you putting on the situation right now?
    - If the situation did not have a label, how would it be different?
    - Where are your choices coming from? From fear? Anger? Worry? Compassion? Love?
    - Checking in with yourself, what do you need?
    - What do you hear right now?
    - What do you see right now?
    - What do you taste right now?
    - What do you feel right now?
    - How does your heart feel right now?

**Adult Group**

- The adult group will be process-oriented and focus on a discussion around helping their children cope after a traumatic event. The facilitator will engage the participants in the following discussion topics/questions:
  - How to increase safety and maintain a calm environment
  - How to establish and maintain day-to-day structure and routine
  - How to find activities with their children that increase shared enjoyment
  - How to engage in developmentally appropriate conversations regarding trauma symptoms and PTSD
  - How each of their children has coped differently with their traumatic stress
  - How to listen and acknowledge feelings
  - How to model and practice relaxation and breathing
- Caregivers will also be encouraged to discuss strategies for communicating their needs with their children. The facilitator will engage the participants in the following discussion questions:
  - Are you meeting your spiritual, emotional, and physical needs?
  - How can you recognize when you need to step away?
  - What are some ways you can communicate needing to take space from your child/children?
  - What would a balanced life look like for you?
  - How can you balance your needs and the needs of your children at the same time?
  - Are there other adults in your life that can offer you support?

**Materials**:

- Emotions Wheel handout
- Colored pencils and/or markers
- Supplies that activate the five senses
- Journals
- Pens/Pencils

**Set-Up**:

- Participants will be separated into three rooms based on age with 1-2 facilitators in each room *(*room assignments by age will be determined during the intake/assessment phase of treatment based on enrollment*)*
- Chairs should be set-up in a circle so that participants can face one another (the child and/or adolescent group can be seated on the floor for increased engagement*)*

**Phase 2: Internal Safety and Stabilization**
**WEEK 5:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:

- Promoting health

**Activities**:

- Facilitators lead the group in a discussion around familial and individual self-care strategies
- Following the discussion on self-care strategies, facilitators will lead the group in a discussion around sleep hygiene using prompts adapted from the Centre for Clinical Intervention *(8)*
    - Does your family go to sleep and wake up at the same time every day?
    - What are some regulation strategies your family engages in before bed?
    - Are you drinking caffeinated beverages before bed?
    - Does anyone in your family frequently take naps during the day?
    - Does anyone in your family engage in other activities in bed like watching television, using cellphones, or work?
    - Does your family regularly engage in exercise and eat a balanced diet?
    - Are the rooms designated for sleeping comfortably (e.g., dark, quiet, and cool)?
- Following the discussion on sleep hygiene, facilitators will provide psychoeducation around the benefits of behavioral activation using a behavioral activation guide from Therapist Aid *(9)*
- The multi-family group session concludes with the facilitator playing music and inviting each member of the family to engage in physical movement (e.g., stretching in place, dancing, walking around the room, etc.)
- Before the break, each family is given a coping skills handout to take with them to their age-specific group rooms *(10)*

**Materials**:

- Table and Chairs
- Device for playing music
- Behavioral activation guide
- Coping Skills handout

**Set-Up**:

- Table and chairs for each family/family members

***Break/Transition (10 minutes)***

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**Phase 2: Internal Safety and Stabilization**
**WEEK 5:** Part 2

**Length**: 50 minutes
**Format**: Group Therapy by Age

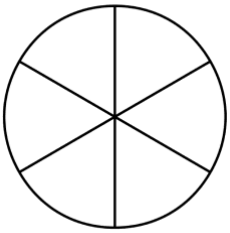
**Objectives**:

- Establishing coping skills

**Activities by Age Group**:

**Child Group**

- Facilitators guide participants in the creation of a coping strategies wheel with the following instructions as a guide *(11)*:
  - Have each participant cut out two even large circles traced on two separate pieces of construction paper (it may be helpful for this exercise to have a few pre-cut circles that can be used for tracing)
  - Take one of the circles and divide it into six even spaces like this:



  - Instruct the participants to decorate each space to represent a coping strategy (participants can use words, illustrations, or both). Encourage them to use the handout that was passed out at the end of the multi-family session for reference
  - The other circle will be divided into six equal spaces with fine lines that can be easily erased. Pick one of the triangles and cut out an opening. Erase the existing lines and instruct the participants to decorate the top as they please
  - The circle with the cut out will be placed on top of the other circle. Assemble the two circles by poking a small hole in the middle and placing a fastener
  - Have the participants sit in a circle at the end and share their coping strategies wheel with their group members

**Adolescent Group**

- The adolescent group will complete the same exercise as the child group using the same instructions
  - If the adolescent group is too advanced to complete the coping strategies wheel, lead them in a discussion around coping skills using the handout as a reference and have them write down three coping strategies on a blank note card to take with them

**Adult Group**

- The facilitator instructs the participants to fill out a self-care wheel using the following instructions as a guideline:
  - Provide the participants with a pre-made template of a circle divided into six equal parts with headers on the outside of each section. The headers should have the following titles:
    - Psychological
    - Spiritual
    - Personal
    - Professional
    - Physical
    - Emotional

- Instruct each participant to fill out each section with self-care strategies that will enhance each area
- The self-care wheel should look something like this *(12)*:


**Materials**:

- Construction paper
- Colored pencils and/or markers
- Coping skills handout
- Scissors
- Fasteners
- Self-Care Wheel handout (blank)
- Pens/Pencils
- Blank notecards

**Set-Up**:

- Participants are separated into three rooms based on age with 1-2 facilitators in each room (room assignments by age will be determined during the intake/assessment phase of treatment based on enrollment)
- Chairs should be set-up in a circle so that participants can face one another (the child and/or adolescent group can be seated on the floor for increased engagement)

**Phase 2: Internal Safety and Stabilization**
**WEEK 6:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:

- Review of coping skills
- Introduction to negative thought patterns
- Discussion on empowerment
- Discussion on self-compassion

**Activities**:

- To start the session, facilitators lead the group in a check-in on how coping skills were used between sessions

- The remainder of the group session will be used to review a handout on common negative and positive beliefs/affirmations *(13)*
- Following the review, each family member is handed a blank notecard and asked to write down three positive affirmations to increase empowerment and self-compassion

**Materials**:

- Common negative beliefs and positive beliefs handout
- Blank notecards
- Colored pencils and/or markers
- Pens/Pencils

**Set-Up**:

- Table and chairs for each family/family members
- Place blank notecards and colored pencils, markers, and pens on each table

***Break/Transition (10 minutes)***

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**Phase 2: Internal Safety and Stabilization**
**WEEK 6:** Part 2

**Length**: 50 minutes
**Format**: Group Therapy by Age

**Objectives**:

- Practice challenging negative thought patterns
- Practice using positive affirmations

**Activities by Age Group**:

**Child Group**

- The facilitators will lead the group in creating a negative thoughts monster using a tissue box. Using various materials (e.g., stick-on googly eyes, construction paper, feathers, yarn, paint, markers, etc.) have the participants decorate the tissue box by creating a face, hair, and teeth
- Process the activity by having the participants sit in a circle and explain that the box will be used to eat up all the negative thoughts they have about themselves
    - If they are comfortable, they can also share a negative thought for their monster to eat, followed by an affirmation

**Adolescent Group**

- The adolescent group will put together an identity collage of various pictures that represent their strengths. Using a stack of magazines, have the participants cut out a set of pictures or words and glue them together on a piece of construction paper

**Adult Group**

- The adult group will be process-oriented and focus on following prompts as a guide to build empowerment and self-compassion:

- Do you experience any guilt as a parent for what happened to your child/children? What is that like for you?
- What are the messages you tell yourself about your ability to parent?
- What are your strengths as a caregiver?
- What are your strengths as an individual?
- What are you most thankful for?
- What do you have control over?
- What don't you have control over?
- What is something you're proud of that you accomplished in the last week, month, or year?
- Who do you turn to in times of need?
- What are some goals you've accomplished?

**Materials**:

- Tissue box
- Decorating materials for the tissue boxes (e.g., stick-on googly eyes, construction paper, feathers, yarn, paint, markers, etc.)
- Scissors
- Magazines
- Construction paper
- Colored pencils and/or markers

**Set-Up**:

- Participants will be separated into three rooms based on age with 1-2 facilitators in each room (room assignments by age will be determined during the intake/assessment phase of treatment based on enrollment)
- Chairs should be set-up in a circle so that participants can face one another (the child and/or adolescent group can be seated on the floor for increased engagement)

**Phase 2: Trauma Processing**
**WEEK 7:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:

- Impact of trauma on the family
- Acknowledging family strengths

**Activities**:

- Facilitators will review The National Child Traumatic Stress Network Trauma and Families Fact Sheet for Providers *(14)*
- Following the discussion, families will work with their therapist to discuss familial strengths
- After discussing family strengths, each family will put together a strengths puzzle

- Each family member will be asked to share an individual strength and write it down on a blank puzzle piece that will be provided to them. The final product will be a representation of every family member's strengths coming together

**Materials**:
- Tables and chairs
- Blank puzzle pieces
- Markers
- Trauma and Families Fact Sheet for Providers handout

**Set-Up**:
- Table and chairs for each family/family members
- Blank puzzle pieces and markers should be placed on each table

***Break/Transition (10 minutes)***

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**Phase 3: Trauma Processing**
**WEEK 7:** Part 2

**Length**: 50 minutes
**Format**: Family Therapy

**Objectives**:
- Review safety
- Develop a hierarchy of stressors
- Self-care plan

**Activities**:
- Before beginning trauma processing, the facilitator will review the family safety plan
- Once the safety is reviewed and updated if necessary, the facilitator will present the family with a large poster and a set of sticky notes. The family will be instructed to draw a line from one end of the poster to another. Once the line is drawn, have the family work together to write down a list of events, environmental stressors, or feared stimuli from moderate to severe and place the sticky notes on the line in order
- Process the activity by letting the family know that the moderate stressor will be processed first and that together, the facilitator and the family will gradually work towards processing the most severe stressor at the pace of the family or individual when/if they are ready
- Before concluding the family session, work with the family to create a self-care plan to be completed after the session

**Materials**:
- Safety plan
- Poster
- Markers

- Sticky notes

**Phase 3: Trauma Processing**
**WEEK 8**

**Length**: 120 minutes
**Format**: Family Therapy

**Objectives**:
- Review hierarchy of stressors
- Discussion around trauma avoidance
- Review safety
- Create impact statement
- Self-care plan

**Activities**:
- Before beginning the session, family therapists will review the hierarchy of stressors from the prior session and finish processing the activity, if necessary
- Family therapists will then review trauma avoidance with the family using this prompt from The U.S. Department of Veteran Affairs (2007):
  - "Avoidance is a common reaction to trauma. It is natural to want to avoid thinking about or feeling emotions related to a traumatic event. But when avoidance is extreme, or when it's the main way you cope, it can interfere with your emotional recovery and quality of life" (para. 1)
- Continue the conversation by writing out a list of pros and cons for avoiding trauma on a large poster board *(15)*
- Before continuing the family session, facilitators will review any safety concerns that the family might have and go over or update the family safety plan if needed
- Following the safety plan review, each family will work with a facilitator to develop an impact statement. The impact statement will be a representation of how the family as a whole was impacted by the traumatic event(s). The statement will include how the event(s) affected their view of themselves, other people, and the world
- The remainder of the session is spent processing the impact statement using skills from prior weeks and creating a family self-care plan to be completed after the session

**Materials**:
- Safety plan
- Poster board
- Markers
- Blank sheet of paper
- Pens/Pencils

**Phase 3: Trauma Processing**
**WEEK 9**

**Length**: 120 minutes

**Format**: Individual or Family Therapy

**Objectives**:
- Review safety plan
- Developing the trauma narrative
- Self-care plan

**Activities**:
- Before beginning the family or individual session, facilitators will review any safety concerns that the family or individual might have and go over or update the family safety plan if needed
- After reviewing safety, the family or individual will begin developing their trauma narrative. The therapist can use the following prompts as a guideline for developing the trauma narrative by chapters adapted from *Trauma Systems Therapy for Children and Teens* (Ellis & Brown, 2016):
  - Introduction of child
  - Description of family members
  - Recalling the trauma
  - Acknowledging changes
  - Acknowledging what stayed the same
  - Identifying supports
  - Preventing future abuse
  - Remembering coping skills
  - Positive outcomes after the trauma occurred
  - Future goals and aspirations
- For chronic trauma, the therapist and child or family can also develop a timeline. Rather than recalling a singular event, the child or family can verbally sequence events across the lifespan to create a cohesive story
- Before concluding the family session, work with the family to create a self-care plan to be completed after the session

**Materials**:
- Safety plan
- Blank sheets of paper
- Colored pencils and/or markers

## Phase 3: Trauma Processing
## WEEK 10

**Length**: 120 minutes
**Format**: Individual or Family Therapy

**Objectives**:
- Review safety plan
- Developing the trauma narrative
- Self-care plan

**Activities**:

- Before beginning the family or individual session, facilitators will review any safety concerns that the family or individual might have and go over or update the family safety plan if needed
- After reviewing safety, the family or individual will continue developing their trauma narrative. Emphasize that the focus will first be on the moderate stressor and work its way up to the severe stressor as was demonstrated in the exercise completed week eight
- Before concluding the family session, work with the family to create a self-care plan to be completed after the session

**Materials**:

- Safety plan
- Trauma narrative
- Colored pencils and/or markers

**Phase 4: Building Resiliency and Social Engagement**
**WEEK 11:** Part 1

**Length**: 60 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:

- Warning signs of future abuse
- Introduction to post-traumatic growth

**Activities**:

- Facilitators will lead the multi-family group in an open discussion around signs of future abuse using a handout from Defend Innocence that reviews perpetrator grooming behaviors every parent should know *(16)*
- Following the discussion on signs of future abuse, the facilitators will introduce the topic of post-traumatic growth using a handout from echo *(17)* that reviews the following five domains:
    - Personal Strengths
    - Closer Relationships
    - Greater Appreciation for Life
    - New Possibilities
    - Spiritual Development
- To conclude the session, families will break apart in the multi-family group room with their family therapists and work on a beneficial word marble. The family therapist will review positive affirmations and instruct each family member to write one positive word on a small piece of paper (it may be helpful to have the small piece of paper pre-cut and fitted to the marbles before beginning the session) and glue it to a translucent marble
- The family will then be instructed to take the marble home and place it somewhere safe (e.g., nightstand, wallet, bathroom counter, etc.) where it can be easily accessed as a daily reminder of strength and recovery

**Materials**:
- 6 Perpetrator Grooming Behaviors Every Parent Needs to Know
- Post-Traumatic Growth handout
- Translucent marbles
- Small pieces of paper pre-cut to fit marbles
- Scissors
- Clear glue stick

**Set-Up**:
- Table with chairs for each family/family member
- Each table should have a set of translucent marbles, small pieces of paper pre-cut to fit the marbles, clear glue sticks, and markers

***Break/Transition (10 minutes)***

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**Phase 4: Building Resiliency and Social Engagement**
**WEEK 11:** Part 2

**Length**: 50 minutes
**Format**: Family Therapy

**Objectives**:
- Assessment of post-traumatic growth with individual family members and the family as a whole

**Activities**:
- The family therapist will take the entire session to lead the family in a discussion around areas of growth and resiliency that they have observed in themselves and one another since beginning treatment

**Materials**:
- No materials needed

**Phase 4: Building Resiliency and Social Engagement**
**WEEK 12**

**Length**: 120 minutes
**Format**: Multi-Family Group Therapy

**Objectives**:
- Group dinner
- Goals for the future
- Certificate of completion ceremony

**Activities**:

- For the final session, the multi-family group will gather and share a meal provided by the facilitators
- After the meal is distributed, the families will break apart in the multi-family group room and begin discussing with their family therapist individual and family goals for the future
- Once the families have completed their meals and share future goals with their family therapist in separate groups, the families will gather together and share individual and/or family goals with the entire group
- The final session will be completed by presenting certificates of completion to each participant

**Materials**:

- Catered meal for the family
- Plates
- Napkins
- Forks/Spoons/Knives
- Certificates

**Set-Up**:

- Tables with chairs set-up for each family/family members
- A table should be set-up with food that can be served buffet style

# Appendix B

## Resources and Handouts

**Week One**
**1:** Power and Control Wheel

**Week Two**
**2:** Impacts of Trauma Worksheet
**3:** Genogram Guide

**Week Four**
**4:** Stress and Early Brain Growth: Understanding Adverse Childhood Experiences (ACEs)
**5:** Window of Intolerance
**6:** Progressive Muscle Relaxation Exercise
**7:** My Emotions Wheel

**Week Five**
**8:** Sleep Hygiene
**9:** Behavioral Activation Guide
**10**: Coping Skills
**11:** Coping Strategies Wheel
**12:** Self-Care Wheel

**Week Six**
**13:** Negative and Positive Beliefs

**Week Seven**
**14:** The National Child Traumatic Stress Network Trauma and Families Fact Sheet for Providers

**Week Eight**
**15:** Avoidance

**Week Eleven**
**16:** 6 Perpetrator Grooming Behaviors Every Parent Needs to Know
**17:** Post-Traumatic Growth