CURRICULUM DEVELOPMENT FOR SHELTERED YOUTH WHO ARE VICTIMS OF DOMESTIC VIOLENCE

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Abstract

of

CURRICULUM DEVELOPMENT FOR SHELTERED YOUTH
WHO ARE VICTIMS OF DOMESTIC VIOLENCE

by

Alison Ayn Ehlers

A therapeutic intervention in the form of a time-limited group curriculum was developed for child victims of domestic violence. Domestic violence (DV) is defined as a pattern of abusive behavior in any relationship that is used by an intimate partner to gain or maintain power and control over another intimate partner. The abuse can be physical, sexual, emotional, economic, or psychological in nature. DV is frequently perpetrated in the presence of children, and the consequences of such exposure to DV can be severe and long-lasting. Various evidence-based interventions were reviewed and a comprehensive 8-week group curriculum was developed based on the research of Cohen, Mannarino, and Deblinger, the developers of Trauma-Focused Cognitive Behavioral Therapy. An expert evaluation of the curriculum was conducted by 11 clinicians, researchers, and educators. Their responses were collated and summarized, and suggestions and modifications were proposed from which a modified curriculum might be developed.

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Dr. Marya Endriga

__________________________
Date

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Chapter 1

INTRODUCTION

Witnessing violence between parents is a particularly insidious event. It is most likely to occur in the home—the one environment generally associated with safety and protection of the child. It is not surprising, therefore, that exposure to marital violence has been associated with a variety of problems in children. (Margolin, 1998, p. 57)

Domestic violence (DV) in the United States has reached epidemic proportions (Davis & Harsh, 2001). The federal government has made efforts to bring this issue into the public sphere with the passage of congressional bills such as the 1974 Child Abuse Prevention and Treatment Act (Gentry, 1994), the 1984 Family Violence Prevention Services Act (U.S. Department of Health and Human Services [HHS], 2010), and the 1994 Violence Against Women Act (U.S. Department of Justice [DoJ], 2010). However, the fact remains that one in every four women will experience domestic violence in her lifetime (National Coalition Against Domestic Violence, 2007) and there may be as many as 17.8 million children exposed to DV in the U.S. every year (Virginia Commission on Youth, 2011).

Fortunately, in an effort to reach affected women and children, every state in the nation, along with the Virgin Islands, Puerto Rico, and the District of Columbia, has established offices affiliated with the National Coalition Against Domestic Violence (NCADV). According to its website, the NCADV “is devoted to the elimination of domestic violence in urban and rural areas, [and] across all racial, religious, and
economic groups” (NCADV, 2011). It also serves as a membership organization and coalition-builder for agencies nationwide that provide services for victims of DV. Its California affiliate, the California Partnership to End Domestic Violence, lists at least one agency in 51 of the state’s 58 counties that is dedicated to assisting victims of DV. The list, admittedly an incomplete one, lists 107 DV agencies in California. One of two agencies presently operating in El Dorado County, a sizable county in east-central California encompassing 1,805 square miles of foothills and mountainous terrain, is The Center for Violence-free Relationships, known as “The Center.”

Statement of the Problem

The Center for Violence-free Relationships has provided services to residents in the Northern California foothills for over 30 years. The mission statement of The Center (formerly The El Dorado Women’s Center) is as follows:

The Center for Violence-free Relationships is dedicated to building healthy relationships, families, and communities free from sexual assault and domestic violence through education, advocacy, and services in western El Dorado County.

(The Center for Violence-free Relationships, 2010a, p. 5)

Among its many services, The Center operates a shelter (a free-standing residential dwelling in an unidentified location) for female victims of DV and their children. While in residence at the shelter, which can range from 30 to 90 days, mothers are invited to attend weekly group and individual counseling sessions at The Center. Among other things, these sessions help reduce a woman’s isolation, provide acceptance and trust-building experiences, promote awareness and personal empowerment, and “banish
confusion” (The Center, 2010b). However, no such program exists for children residing at the shelter despite the fact that, according to Volpe (1996), common symptoms of children who witness DV include sleep problems, eating disturbances, low self-concept, withdrawal from peers, oppositional-defiant behavior, and rebelliousness at home and at school. Depending on the age of the child, it is also not uncommon to observe temper tantrums, fighting between siblings, cruel treatment of pets, abuse toward peers, and attempts to gain attention by kicking, hitting, or choking peers or family members. This behavior perpetuates what is called an intergenerational cycle of violence (Widom, 1995; Korbin, Anetzberger, & Austin, 1995). According to the U.S. Department of Justice:

Frequent exposure to violence in the home not only predisposes children to numerous social and physical problems, but also teaches them that violence is a normal way of life - therefore, increasing their risk of becoming society's next generation of victims and abusers. (2010, para. 4)

The impact of witnessing DV can be devastating for children. They might suffer extensively and find themselves vulnerable to a host of short- and long-term problems and pathologies (Groves, 1999) including post-traumatic stress disorder (Margolin & Vickerman, 2007).

**Purpose of the Project**

There are presently no structured therapeutic services in El Dorado County available to children who find themselves uprooted from their homes and placed in a DV shelter. One reason for this might be that, although the traumatic stress a child experiences as a result of family violence is more common than, for example, the
stressors of child sexual abuse, it has received less attention in the research literature (Margolin & Vickerman, 2007).

The purpose of this project is to develop a curriculum for children staying at The Center’s emergency shelter that addresses some of their emotional and psychological needs. The curriculum will be designed to teach its participants necessary life skills and will provide them with tools that will enable them to express their emotions in nonviolent ways. The curriculum will also attempt to teach them how to effectively develop positive behavior patterns, cope with unpredictable emotional events, comprehend boundaries, enhance personal safety, and be empowered through esteem-building exercises. Additional objectives will include teaching children the differences between thoughts, feelings, and behaviors, and providing them with an opportunity to communicate more effectively with their non-offending parent. More specifically, an evidence-based practice will be investigated and selected that is adaptable to the specific circumstances in which it will be used by The Center; that is, it will be effective 1) in a group setting, 2) for a wide range of ages, and 3) in a time-limited format. It will also be critical that the non-offending parent, in this case the mother, be integrated into the curriculum so that the child’s healing can take place in a supportive and transparent environment.
Chapter 2

REVIEW OF THE LITERATURE

Definitions of Domestic Violence and Related Terms

Even though continued research over the past 35 years has increased our understanding of domestic violence, the phenomenon is not easily categorized. Various definitions and taxonomies regarding DV prevail in clinical literature and in state and federal laws. As of 2008, approximately 46 states and Washington D.C. had varying definitions of DV in their civil statutes and terms such as “domestic violence,” “abuse,” “intimate partner violence (IPV),” “family violence,” and “domestic abuse” were used (Administration on Children, Youth and Families, July 2008; CDC, 2009). “Spouse abuse,” “courtship violence,” “battering,” “marital rape,” “spousal assault,” and “date rape” also refer to DV (Basile, Hertz, & Back, 2007). Fortunately, the Office on Violence Against Women, a component of the U.S. Department of Justice, provides comprehensive and legally binding definitions that assist in explicating the various facets of DV. It states:

Domestic violence can be defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. (U.S. Department of Justice [DoJ], 2010)
Examples of the five types of domestic violence described by the Department of Justice (DoJ, 2010) are as follows:

Physical abuse includes hitting, slapping, shoving, grabbing, pinching, biting, hair-pulling, and so on. It can also include forcing drugs and alcohol on a partner, or denying her medical care. Sexual abuse is defined as coercing or attempting to coerce any sexual contact or behavior without consent. This includes events such as marital rape, forcing sex after physical violence has occurred, treating an individual in a sexually demeaning way, and attacks on sexual parts of the body. Emotional abuse includes constant criticism, name-calling, damaging a relationship with one’s children, or diminishing one’s abilities. Economic abuse are actions such as withholding one’s access to money, forbidding one to attend school or get a job, or making an individual financially dependent by maintaining total control over financial resources. Psychological abuse encompasses a plethora of scenarios, such as intimidation resulting in fear, destruction of pets and property, the isolation of an individual from her family and friends, or the threat to harm oneself, one’s partner, the children, or the partner’s friends and family. The Department of Justice (2010) asserts that:

Domestic violence can happen to anyone regardless of ethnicity, age, sexual orientation, religion, or gender. Domestic violence affects people of all socioeconomic backgrounds and education levels. Domestic violence occurs in both opposite-sex and same-sex relationships and can happen to intimate partners who are married, living together, or dating.

Finally, note that domestic violence is, in fact, a crime in every state in the country.
Prevalence of Domestic Violence

Just how common is domestic violence? The Centers for Disease Control and Prevention consider it “a serious problem in the United States” (CDC, 2009, p. 1). In 2007, the National Coalition Against Domestic Violence (NCADV) reported that each year approximately 1.3 million women are physically assaulted by an intimate partner. When the CDC added incidents of rape by an intimate partner to the number of physical assaults, the total annual number came to 4.8 million. In 2005, 1,510 deaths resulted from domestic violence, 78% (1,178) of whom were females (CDC, 2009). In 1995, the cost of domestic violence in terms of medical care, lost productivity, and mental health services was $5.8 billion. In 2003 that amount was adjusted for inflation and the cost of DV came to $8.3 billion (CDC, 2009).

In addition to the startling statistic that one in every four women will experience domestic violence in her lifetime, the National Coalition Against Domestic Violence (NCADV, 2007) states that females are most often victimized by someone they know, that females who are 20-24 years of age are at the greatest risk of nonfatal intimate partner violence, and that almost one-third of female homicide victims are killed by an intimate partner. As for the impact of DV on our mental health system, the NCADV (2007) reports that 18.5 million mental health care visits each year are a result of intimate partner violence. Indeed, both physically and emotionally, “the consequences of domestic violence can cross generations and truly last a lifetime” (NCADV, 2007, p.1).

Although these statistics are compelling, they do not fully illustrate the problem. The NCADV notes that “less than one-fifth of victims reporting an injury from intimate
partner violence [seeks] medical treatment following the injury” (NCADV, 2007, p.1).

The Centers for Disease Control and Prevention also warn the numbers they publish are an underestimate of the problem, and that victims often do not report intimate partner violence (IPV) to the police, friends, or family because they think the police will not be of any help and that their friends and family will not believe them (CDC, 2009).

Women are not the only victims of domestic violence. Every year in the U.S. approximately 2.9 million men are physically assaulted by an intimate partner (CDC, 2011). For a variety of reasons men, like women, are loath to report the violence or seek assistance. The fear of not being believed, the stigma of being a male victim in a “macho” society, and the lack of support from friends and family prevent men from reporting the violence. It should be noted that most cases of intimate partner violence against men are committed in same-sex relationships rather than in heterosexual relationships (NCADV, n.d.; see also Tjaden, P. & Thoennes, N., 2000). Additionally, whereas a male victimized by a female is more likely to be slapped, kicked, or have objects hurled at him, a male victimized by another male is more likely to be beaten with closed fists, strangled, or be threatened with various weapons.
History of Domestic Violence

The epidemic of domestic violence in the U.S. and internationally is not a recent social crisis; DV has plagued women for centuries. According to Wadman, Foral, and Dryden-Edwards, it “has a long, dark past and is firmly entrenched in many societies” (2007, para. 1). Although certain women in the Mediterranean were given the right to sue their husbands for unjustified beatings as early as 202 BCE, Catholic fathers reimposed a firm patriarchal hierarchy by the 4th century and, throughout the Middle Ages, “squires and noblemen beat their wives as regularly as they beat their serfs” (Minnesota Center Against Violence and Abuse [MINCAVA], 1999, Table 1, para. 4).

The Christian church vacillated between endorsing either compassion or wife-beating for husbands, and the debate continued for centuries. In 18th century England, violence against wives and children was encouraged (MINCAVA, 1999) in order to maintain obeisance toward the male head of the household. Although wife-beating was condemned by early Puritans, the first legal ruling in America to address the notion of “reasonable chastisement” was handed down in 1824, when a Mississippi court preferred not to condemn what went on behind closed doors. The judge in Calvin Bradley v. The State determined that:

Family broils and dissensions cannot be investigated before the tribunals of the country, without casting a shade over the character of those who are unfortunately engaged in the controversy. To screen from public reproach those who may be thus unhappily situated, let the husband be permitted to exercise the right of moderate chastisement in cases of great emergency and use salutary restraints in
every case of misbehavior, without being subjected to vexatious prosecutions, resulting in mutual discredit and shame of all parties concerned. (Nored, 2007, p. 613; Library Index, n.d.)

It was not until the late 19th century that DV became a legitimate social issue. In England, Francis Cobb launched a successful campaign against “wife torture”, which resulted in the Wife Beaters Act of 1882, “allowing courts to confine wife or child beaters in the pillory for up to four hours, and permitting long prison sentences and whipping for a second offense” (Stark & Flitcraft, 1991. p. 45). Although the English determined that life-threatening beatings were justifiable grounds for divorce (late 19th century), Russia awarded women legal equality (1917-1936), Sweden gave women equal rights as parents (1921), France ruled that a husband did not have the right to beat his wife (1924), and Chinese women legally formed local women’s associations after testifying about the beatings against them (1940s) (MINCAVA, 1999), little headway was made in America against DV. Social concerns like negligent mothers and juvenile delinquency overshadowed any focus on spousal abuse, and the issue of battered women did not get significant attention in the U.S. until the 1970s (Columbia University, 1999). Finally, with the growth of the feminist movement, there came a flurry of legislation to protect the rights of women against violence and rape, and the Violence Against Women Act (VAWA) was passed in 1994. VAWA, revised and reauthorized in 2000 and again in 2005, gave victims of violence, including battered women, federal civil rights protection (Law Library Index, 2010).
The Domestic Violence-Child Maltreatment Connection

The staff at The Center for Violence-free Relationships views DV and child maltreatment as inextricable. According to J. Knapp, (personal communication, January 20, 2011), “Domestic violence is child abuse.” Indeed, the children of parents and caretakers who engage in DV often suffer both as witnesses and direct victims of DV. Edleson (1999) reported in the National Electronic Network on Violence Against Women, a project of the National Resource Center on Domestic Violence, that approximately 50% and perhaps as many as 70% of those individuals who batter their wives also abuse their children.

According to the Administration for Children and Families, a division of the U.S. Department of Health and Human Services, definitions involving children and DV differ somewhat from the definitions that constitute DV for adults. The Federal Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as, at minimum, “any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or, an act or failure to act which presents an imminent risk of serious harm” (Administration on Children, Youth and Families, April 2008, p. 2).

Four major types of child maltreatment are recognized by most states: physical abuse, neglect, sexual abuse, and emotional abuse. Physical abuse is described as any non-accidental physical injury or death as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting, burning, or otherwise harming a child, which is inflicted by a parent or caregiver. Note, however, that physical discipline, such
as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child. Neglect is the failure of a parent or caregiver to provide for a child’s basic needs. Neglect may be physical, medical, educational, or emotional. Many states also consider abandonment and substance abuse a form of neglect.

Sexual abuse might include activities by a parent or caregiver such as fondling a child’s genitals, penetration, incest, rape, sodomy, indecent exposure, or exploitation through prostitution or the production of pornographic materials. Emotional abuse (or psychological abuse) is a pattern of behavior that impairs a child’s emotional development or sense of self-worth. This might include constant criticism, threats, or rejection, as well as withholding love, support, or guidance. Such abuse is difficult to prove; however, emotional abuse is almost always present when other forms of abuse are identified (Administration on Children, Youth and Families, April 2008).

The statistics on child victims of maltreatment are as alarming as those on women who are victims of intimate partner violence. According to the National Child Abuse and Neglect Data System (NCANDS), Child Protective Services (CPS) agencies receive approximately 3.3 million referrals of child abuse and neglect each year. In 2008, approximately 1.5 million CPS referrals were investigated and 24% of the investigations determined that at least one child was a victim of child abuse or neglect (Administration on Children, Youth and Families [ACYF], 2010). This translates to approximately 360,000 substantiated reports of abuse or neglect involving one or more children. Just as with incidents of intimate partner violence, however, CPS agency reports might not accurately reflect the frequency of abuse. According to the Administration for Children
and Families (ACF) with regard to child fatalities, “deaths that result from physical assault or severe neglect can be more difficult to track because the perpetrators, usually parents, are less likely to be forthcoming about the circumstances” (ACYF, June 2008, p.1). According to NCANDS, 1,740 children died from abuse and neglect in 2008 (ACYF, 2010); however, in an effort to determine the degree of underreporting in the realm of child maltreatment fatalities, several studies have estimated that “as many as 50-60 percent of child deaths resulting from abuse or neglect are not recorded as such” (ACYF, June 2008, p. 2).

If deaths resulting from child abuse and neglect are underreported, it is not unreasonable to assume that abuse and neglect that injures but does not kill a child is underreported as well. According to Vincent Iannelli (2010), more than 1.25 million, or 1 in every 58 children in the United States, were abused in 2006. Sixty-one percent of the children (771,700) were victims of neglect and 44 percent (553,300) were victims of abuse; the latter category included physical abuse (325,000 children), emotional abuse (148,500 children), and sexual abuse (135,000 children). However, because of shifts in the definitions of trauma, abuse, and domestic violence, a meta-analytic review by Evans, Davies, and DiLillo (2011) revealed that between three and 17.8 million youth are exposed to at least one act of DV annually.

**Consequences of Domestic Violence**

Physical scars from domestic violence can be visible and persistent. Emotional scars are less obvious but are potentially more insidious for both the victims of domestic violence and for the children who witness it or who are abused themselves. Women who
are victims of DV suffer from low self-esteem, and their stress and anger can lead to depression, anxiety, and eating disorders. They engage in harmful health behaviors like smoking, drug and alcohol abuse, and risky sexual activity. They have a difficult time relating to others, and they suffer an erosion of trust in other people. They struggle with suicidal ideation and they try to escape from the trap they are in by attempting or completing suicide (CDC, 2009).

Children exposed to domestic violence consistently show difficulties in three categories. According to the Office on Child Abuse and Neglect at the U.S. Department of Health and Human Services (2003), the first category includes behavioral, social, and emotional problems. Many specific issues fit within this category, including: levels of aggression, anger, hostility, oppositional behavior, disobedience, fear, anxiety, withdrawal, and depression. Poor peer, sibling, and other social relationships are also a problem, as is low self-esteem. In the second category, cognitive and attitudinal problems, children and adolescents may suffer from lower cognitive functioning and poor school performance, lack of conflict resolution skills and limited problem-solving skills, acceptance of violent behaviors and attitudes, and a belief in rigid gender stereotypes and male privilege. The third category encompasses long-term problems. When children and adolescents grow up, they might suffer from higher levels of depression and trauma symptoms, and manifest an increased tolerance for, and use of, violence in adult relationships.

In addition to cognitive/behavioral and psychosocial/emotional issues, the Office on Violence Against Women reports that domestic violence predisposes children to
numerous physical problems and teaches them that violence is a normal way of life, “therefore increasing their risk of becoming society’s next generation of victims and abusers” (U.S. Department of Justice, 2010, para. 4).

**Integrating Services for Domestic Violence**

What steps can a community take to assist individuals who find themselves victimized by domestic violence and child maltreatment? First, it must be stressed that “although researchers have known for years that domestic violence and child maltreatment often coexist in families, only recently have communities and individuals from all professions begun to question the wisdom of responding to these forms of violence as if they were separate, unrelated issues” (Schecter & Edleson, 1999, p. 4).

According to Aron and Olson (1997), programs and agencies historically addressed these issues through two separate service systems: Child Protective Services (CPS) for the children and domestic violence programs for the mothers. Additionally, child welfare agencies in the past did not consider that, in order to address the safety of a child in a violent home, attention should focus on the real possibility that both the mother and the child might be in danger. Instead, they considered that the mother was complicit in failing to protect the child (Aron & Olson, 1997).

Agencies today realize that DV and child maltreatment often occur together and that services for the victims of IPV and their children should be provided in an integrated, holistic fashion. In 1999, reviews were conducted of over 20 years of studies regarding domestic violence and a majority of studies found that, in 30-60% of homes where mothers were battered, the children were maltreated as well (Schecter & Edleson, 1999).
This indicates that if interventions are developed to reduce incidences of domestic violence, they should include psychoeducation, skills training, therapeutic healing, and so on, for both the victim of DV and any children residing in the household.

The Center presently offers counseling for DV victims and abusers, but not for the children residing in homes afflicted with DV. Mindful of this gap in services, The Center compiled a grant request to address the needs of children living in its shelter, with an eye toward eventually expanding the program to all children in the community who are victims of domestic violence. Note that this project attempts to focus on the emotional well-being and healing of all the victims who are affiliated with an occurrence of domestic violence; that is, both the children and the mothers who have recently fled their abusers. In addition, it intends to focus on a specific geographic population: the residents of a rural Northern California community who have been victimized by domestic violence.

The Role of Evidence-Based Practice (EBP)

According to the Social Work Policy Institute, evidence-based practice “ensures that the treatments and services, when used as intended, will have the most effective outcomes as demonstrated by the research. It will also ensure that programs with proven success will be more widely disseminated and will benefit a greater number of people” (Social Work Policy Institute, 2010, para. 1). Definitions of EBPs vary, but the Administration for Children and Families (2010) claims that, in the area of child welfare and therapeutic intervention, evidence-based practices are those that have strong research design, evidence of significant positive effects, sustained effects, and a capacity for
replication. Such practices serve agencies that require evidence of program effectiveness in order to procure funding; agencies must be able to demonstrate the efficacy of a particular protocol so that continued funding can be put in place. Finally, in the present economy with its limited funding opportunities, EBPs help to make sure that limited budgets are put to effective use. The Center, like so many other agencies and organizations, cannot afford to develop and implement a program that has not been repeatedly demonstrated as being effective for specific populations.
Chapter 3
THE CENTER FOR VIOLENCE-FREE RELATIONSHIPS

History and Overview

The Center for Violence-free Relationships (“The Center”) is located in Placerville, California, a rural community 40 miles east of Sacramento in the foothills of Northern California’s El Dorado County. Although just 10,095 citizens reside in the City of Placerville and its surrounding unincorporated areas, El Dorado County has a total population of 181,058 (63% urban, 37% rural) and comprises an area of 1,788 square miles (U.S. Census Bureau, 2011; County of El Dorado, 2010). Despite the extensive area the county encompasses, The Center is one of only two agencies in El Dorado County that specializes in domestic violence and sexual assault, the other being the South Lake Tahoe Women’s Center, which is located over 60 miles away.

The Center was founded in 1980 to meet the needs of “displaced homemakers” (those who “solely have been homemakers but who now, because of dissolution of marriage, must seek employment” [Paisley, Butler, & Arnold, 1981, p. 5]) but soon shifted its focus to domestic violence when it became apparent that many of its clients were fleeing violent relationships. According to its website (www.thecenternow.org), The Center provides a variety of services for county residents, including a 24-hour crisis line, individual counseling, drop-in counseling, and group support for victims; emergency food, clothing, and transportation; legal assistance and accompaniment; a 13-bed shelter for women and children that can house five families; hospital and court accompaniment and advocacy; information and referrals; group counseling for those who have battered
Another service that The Center offers involves pets. In an effort to encourage victims to leave their abusers, The Center created a Safe Pet Program in 2000 (J. Knapp, September 1, 2010). According to the Humane Society of the United States, there is a close link between violent behavior toward people and violent behavior toward animals. Up to 75% of DV victims report their partners have threatened or killed family pets, and women seeking safety at domestic violence shelters are nearly 11 times more likely to report that their partner has hurt or killed pets than women who have not experienced domestic violence. In a Wisconsin study, 75% of battered women with abused pets claimed the abuse occurred in the presence of children (Humane Society of the United States, 2010). Tragically, between 18-48% of battered women delay leaving abusive situations out of fear for the safety of their animals. By assuring victims of DV that it can provide a safe haven for all pets, The Center hopes more women will take the courageous step to leave their abusers.

The Center’s reach continues to expand in the county. According to its Executive Director, The Center’s impact on the community was greater in 2009 than in 2008. In 2009, 454 new DV clients were seen (18% increase), 121 new sexual assault clients were seen (26% increase), over 1,500 counseling sessions were conducted (23% increase), and 2,100 nights of shelter were provided (34% increase). Additionally, volunteers and staff at The Center received 1,200 crisis line calls, made 259 presentations (which reached 3,700 individuals), and provided 4,748 hours of trained volunteer services to its clients.
and the community. Its youngest client was age 12; its oldest client was in her 70s (M. Huckabay, personal communication, September 14, 2010).

**Community Resources in Surrounding Counties**

Despite the wide range of services provided by The Center, it lacks programs that focus on child victims of DV. In an effort to determine if any such programs are in place at surrounding agencies, a review of existing child services was conducted in El Dorado, Sacramento, Placer, and Amador counties. The review yielded six agencies that provide a wide array of services for victims of domestic violence: South Lake Tahoe Women’s Center (60 miles east); Women Escaping A Violent Environment, or WEAVE (42 miles west); Kids First (35 miles west); Placer Extends A Caring Environment for Families, or PEACE for Families (32 miles northwest); Operation Care (33 miles south); and Terra Nova Counseling (34 miles west). Like The Center, most of these agencies provide a 24-hour crisis hotline, peer or professional counseling, legal advocacy, prevention and education, outreach programs, an emergency shelter, and support groups for adult victims of domestic violence. A few provide counseling services for children and their families or peer counseling for teens. None of them, however, have a program in place that offers group counseling for child witnesses/victims of domestic violence and their mothers presently living in a shelter.

Children who are witnesses and victims of domestic violence can suffer long-term difficulties and perpetuate the cycle of violence. This agency review revealed a dearth of services in surrounding counties for such individuals and underscored the importance of
researching, developing, and implementing a therapeutic intervention to serve child witnesses/victims of domestic violence living in El Dorado County.

**The Second Generation Project**

With the goal in mind of implementing a therapeutic intervention for child victims of domestic violence and their mothers, The Center for Violence-free Relationships applied for and received a $60,000.00, 3-year grant from the El Dorado Community Foundation for what is called the Second Generation Project. The intention of the Second Generation Project (SGP) is to create an evidence-based curriculum appropriate for small groups that is multi-session, psychoeducational, and which specifically addresses child trauma associated with family violence. The curriculum is to be developed for children and mothers living in The Center’s shelter and has four primary goals:

1. **Breaking the Silence.** Encourage children to talk about their experience. Talking about their traumatic events in a safe and supportive group environment is the first step towards appropriate integration of the trauma.

2. **Emotional Coping and Development of Positive Behavior Patterns.** In order to heal, children need to identify the reasons why fighting and violence occurs inside their families. Children also need to understand that family violence is not their fault and they are not responsible for managing it. When age appropriate, it is imperative to include sessions about boundaries and their own personal relationships to prevent the replication of violence.
3. Parenting Training. Parents need to uncover and address parental guilt and develop techniques for managing and decreasing their child’s negative behaviors. Give non-abusing parent coping skills to understand and appropriately respond to the child’s sadness and sense of loss and desire to maintain a relationship with the abusing parent.

4. Creating a Healing Environment. Help the family create a safe, stable, and nurturing environment for the child. Help parents with consistent routines and reinforce the bond between child and non-abusing parent. For example, if the child is suffering from insomnia and nightmares, the parent works with the child to build soothing and comforting rituals into bedtime stories (The Center for Violence-free Relationships, 2010c).

Soon after The Center was awarded the grant, a committee was formed that consisted of The Center’s Executive Director, the Director of Education and Training, the Shelter Coordinator, and a retired Director of Pupil Services who also serves on The Center’s Board of Directors. An MFT intern, a Blue Shield Administration Manager, and this author also sat on the committee. The committee met twice a month and each member was responsible for a different facet of program development, such as creating a project task list, developing a shelter playroom work plan, creating a materials list, completing quarterly reports, creating PowerPoint presentations for the funding foundation, and writing a job description for the position of therapist. I was tasked with researching various therapeutic curricula and selecting a program that was suitable for The Center’s population of shelter clients. Once an intervention was selected and
approved by the committee, I was to develop a program that included needs assessment tools, a time-limited group curriculum, and program evaluation forms.
Chapter 4

METHOD

Research Evidence-Based Interventions for the Prevention and Treatment of Child Victims of Domestic Violence

Prevalence of Interventions

In order to select an appropriate intervention for child victims of domestic violence, various electronic searches were conducted on the World Wide Web using search terms such as domestic violence, domestic abuse, and child abuse. It was important to find reputable sources that provided information about various evidence-based practices being used in the U.S. Fortunately, after the passage of the Child Abuse Prevention and Treatment Act in 1974, the federal government encouraged the research and development of strategies to address the challenges facing the prevention and treatment of child neglect and abuse. Organizations in areas of mental health, education, law, medicine, and social services developed various approaches and protocols and, by 1977, the National Center on Child Abuse and Neglect (NCCAN) had developed 21 manuals to provide guidance to professionals charged with protecting children (Urquiza & Winn, 1994).

Presently, the online National Registry of Evidence-based Programs and Practices (NREPP), overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA), lists 35 programs that address child abuse and 14 programs that address domestic violence. The Administration for Children and Families, an agency within the U.S. Department of Health and Human Services, offers 100 publications that address
domestic violence. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) lists an impressive 206 programs that help facilitate therapeutic change in children and families, 72 of which directly address child maltreatment. These programs, however, have varying degrees of credibility as reliable, well-researched, evidence-based practices.

Rating Evidence-Based Practices

As mentioned, the California Evidence-Based Clearinghouse for Child Welfare (CEBC) details 206 programs that focus on child welfare, but not all of them have high marks for being an evidence-based practice. The CEBC uses two scales to determine the relative quality of programs. The CEBC Scientific Rating Scale determines the strength of the research evidence that supports each of the programs and the Child Welfare Relevance Rating Scale rates each program based on its relevance to child welfare. A score of 1 on the Scientific Rating Scale’s 5-point Likert-type scale indicates a program is “well-supported.” This means the program has been proven to be superior to a comparison practice in at least two rigorous, randomized control trials. In addition, the program includes a manual that explicates its components and administration, its outcome measures are reliable and valid, and there has been no evidence of any risk of harm to those receiving the intervention. A score of 5 indicates a program has a low degree of research support and is thus a “concerning” practice. A score of 1 on the Child Welfare Relevance Rating Scale’s 3-point Likert-type scale indicates a program has high relevance to child welfare populations, and a score of 3 indicates it has low relevance to such populations. Additionally, a score of NR (Not able to be Rated) on both scales
indicates that no published, peer-reviewed study using some form of control has been conducted on the practice (California Evidence-Based Clearinghouse [CEBC], 2011). Programs listed under *Domestic/Intimate partner Violence: Services for Women and their Children* received ratings of 2, 3, or NR on the Scientific Rating Scale, as did programs listed under *Interventions for Neglect*. Such less-than-ideal ratings did not warrant further investigation of these programs.

**Comparing Evidence-Based Practices**

Desiring to procure a program with laudable ratings and research to support its efficacy, a review of the 14 programs listed under *Domestic Violence* in the National Registry of Evidence-based Programs and Practices (NREPP) was conducted. As mentioned, the NREPP is a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), a subsidiary of the U.S. Department of Health and Human Services. The NREPP is a searchable online registry of over 200 interventions that support mental health promotion and treatment, as well as substance abuse prevention and treatment (NREPP, 2011a). Although it is not an exhaustive list of evidence-based interventions, its purpose is to assist the public in identifying scientifically-tested approaches that can be readily implemented in various populations. One of its goals is to “reduce the lag time between the creation of scientific knowledge and its practical application in the field” (NREPP, 2011b). It provides general information about specific interventions as well as a description of their research outcomes, ratings of the interventions’ quality and readiness, and contact information in
order to procure additional information about the training required to implement the programs.

The 14 programs listed under Domestic Violence were investigated to determine their appropriateness for The Center based on population served, target behavior, age served, length of therapist training required, cost of training, program length, and NREPP rating. In addition to the 14 programs listed on the NREPP, five other interventions I frequently noted in the research literature as having efficacious outcomes for children were reviewed as well.

**Develop Needs Assessment Tools for Child and Parent Clients**

The Second Generation Project consists of three components: 1) client files, 2) an 8-week curriculum, and 3) program evaluations. Client files are a critical aspect of the program because they form the backbone of the initial clinical interview conducted by the therapist with the child and his/her mother. According to the Sommers-Flanagans (2003), “Initiating counseling or psychotherapy without adequate assessment is ill-advised, unprofessional, and potentially dangerous” (p. 7).

It was necessary to create both a Child Client File and a Parent Client File that contained assessments and checklists so that a thorough history of all SGP participants could be obtained during the initial interview. Numerous published inventories and questionnaires were reviewed to determine the most appropriate assessment tools for the shelter population. According to the Sommers-Flanagans (2003), it was also ethically imperative that an explanation of all important facets of the SGP curriculum be provided to the clients that included the risks and benefits, as well as an opportunity for the clients
to freely consent to or abstain from participation in the project. Therefore, an informed consent form was created that clearly explained the program’s format. In addition, templates for log sheets and process notes were created. Other forms that The Center presently makes available for its client files were revised and adapted for the shelter population. Numerous revisions of most forms were made, submitted to the SGP committee for approval or suggestions, revised, and submitted again for final approval.

**Curriculum Development**

Various aspects had to be considered in order to construct a curriculum, such as the proper training method and differing learning characteristics (Sanchez, 2010). In order to elucidate every aspect of the curriculum so that future facilitators might implement the training method with consistency, I used a blank template for curriculum development to outline each element of the sessions. The initial elements identified for each session included the title, the subjects to be discussed, the session objectives, the name of the presenter, and the names of the assistants. Every minute of the sessions was accounted for and the following aspects of each lesson were identified according to The Center policy: topic, duration of lesson, topic objectives, content, delivery approach, activities, materials, and miscellaneous notes/adaptations as needed.

**Program Evaluation Tools**

It is important to conduct an evaluation of the curriculum in order to ensure proper measured outcomes. Kirkpatrick (1994) notes that evaluations can provide a variety of information to the program developers, such as how future programs should be improved and whether or not a program should be continued or dropped. Although not
all programs at service agencies have the resources to do a thorough evaluation, Kirkpatrick lists four critical levels of program evaluation that should be completed, if at all possible: (a) Reaction, (b) Learning, (c) Behavior, and (d) Results. Evaluation tools were developed to address three of the four levels. The final level, Results, is more difficult to assess because SGP participants are in the program for a limited period of time and, according to Kirkpatrick (1994), thoroughly evaluating the results of a training or intervention tends to take a long time.

**Expert Evaluators**

With the assessments, curriculum, and evaluations in place, an expert evaluation of the material was determined to be the next critical step in the program’s development because it would provide valuable feedback and a unique perspective from professionals whose experience is related to the goals of the Second Generation Project. Curriculum feedback from expert evaluators could then be used to further modify and refine the curriculum for the specific population served by The Center. Therefore, a qualified and diverse group of experts in areas of education, clinical work, training, research, public service, and private practice was recruited to review a curriculum packet that consisted of project overviews, child client files, the curriculum, and participant evaluations. They were then asked to complete and return a 3-page evaluation form.

Experts were recruited based on their professional reputations as researchers, scholars, or clinicians who work with child abuse or DV populations. They were identified through the literature, referred by other experts, or personally known by this author. A total of 14 experts consented to review the curriculum packets and 11
completed and returned them. Included in the roster of evaluators were 3 university professor/researchers, 2 psychiatry professor/medical directors, 1 psychologist, 1 trauma therapist, 2 marriage and family therapists, 1 educator at a residential treatment facility for emotionally disturbed adolescents, and 1 trauma therapy trainer. Seven were based in California, 2 in Pennsylvania, 1 in Massachusetts, and 1 in Alaska. Note that two experts were contacted because of their direct involvement in the development and continuing research of the therapeutic intervention that was finally selected for the curriculum.

Curriculum packets were either mailed or hand-delivered to the evaluators and each was asked to respond within 6-10 days. In addition to receiving a hard copy of the evaluation form in their packet, an electronic copy of the form was e-mailed to each evaluator so that he/she could conveniently type responses/comments on the form and e-mail it back. This facilitated in ease of response and also saved evaluators time and money, as they did not have to mail the forms back via USPS First Class Mail.

Evaluators received five overviews that explained the following: (a) the evaluation that was being asked of them, (b) the Second Generation Project, (c) the therapeutic intervention, (d) the curriculum, and (e) the program evaluations (see Appendix A). They also received a sample of the documents contained in the Child Client File, the Curriculum, and the two Participant Evaluations. Appendices containing document samples are described and cited below. Experts were invited to keep the curriculum packets once they had completed and returned the evaluation for their own files in appreciation of their participation and in order to save money on shipping costs.
Review of Expert Evaluations

A 3-page Expert Evaluation Form was created to solicit responses about the three primary aspects of the curriculum packet; that is, the child client file, the curriculum, and the participant evaluations (see Appendix B). The form solicited demographic information such as job title, areas of expertise, years of clinical experience, curriculum development, and so on, and followed with 18 open-ended questions. Evaluators were asked to give their impressions of the child client file and to note whether it contained the necessary tools for an adequate clinical assessment. After reviewing the curriculum, evaluators were asked to comment on whether the session topics satisfied the session objectives, if there was an adequate balance of learning modalities to satisfy the various learning styles of the participants, and whether the objectives of each session met the following curriculum goals: (a) awareness/education, (b) skill-building, (c) connection with mother, and (d) reduction of trauma symptomology. Experts were also asked to review the two participant evaluation tools and comment on whether the pre-test/post-test adequately evaluated skills learned in the program and whether the evaluation form solicited the feedback needed to improve the curriculum for future sessions. Finally, experts were invited to share any final thoughts they had about the curriculum, both positive and negative.
Chapter 5

RESULTS

Evidence-Based Interventions for the
Prevention and Treatment of Child Victims of Domestic Violence

Intervention Guidelines

Fourteen interventions listed under Domestic Violence in the National Registry of Evidence-based Programs and Practices (NREPP) were evaluated. In order to compare programs, eight guidelines were established based on the requirements of the Second Generation Project grant and the needs of The Center for Violence-free Relationships. The eight guidelines are:

1. Population Served: Programs are often ideally suited for a specific demographic group, such as women, children, parents, teens/adults, or criminal offenders.

2. Target Behavior: Programs traditionally target specific behavior issues such as substance use, psychosocial maladjustment, trauma, depression, sexual abuse, or neglect.

3. Age Served: Programs are developed for specific populations and specific age groups within those populations, such as young adults, parents, children aged 0 to 30 months, adults aged 18-55, children aged 6-12, and so on.

4. Length of Training: In order to effectively implement a program, therapists must undergo a certain amount of training and, often, participate in follow-up consultation calls or visits. Program trainings vary. They can take place online, facilitators can be hired to conduct them onsite at an agency, therapists can attend
full clinical trainings of 1-10 days, or therapists can participate in internships of up to one year. In addition to follow-up consultations, advanced trainings might be recommended by a program’s developers.

5. Cost of Training: The cost of becoming proficient at utilizing an intervention varies tremendously. Interventions such as the Curriculum-Based Support Group (CBSG) cost a moderate $300 and include a 2-day training, a facilitator’s manual, ongoing support, technical assistance, and quality assurance tools. Other training programs, such as Child-Parent Psychotherapy (CPP), can be conducted in group sessions for agency staff, but cost up to $3,000 per day and consist of three 3-day workshops, bimonthly clinical consultations, and textbooks. Required phone, e-mail, or in-person consultations cost $150-$350 per hour and an agency might incur additional travel expenses.

6. Program Length: Interventions can require a participant’s commitment of as little as one day, such as the Brief Alcohol Screening and Intervention for College Students (BASICS) program; or, they can require a commitment of up to one year, such as Child-Parent Psychotherapy. Most interventions are implemented in a span of eight to 24 weeks.

7. Rating: The NREPP provides a Readiness for Dissemination rating for each intervention. It “summarizes the amount and general quality of the resources available to support the use of the intervention” (2011c, para. 1). These ratings apply to the intervention as a whole, and higher scores indicate that higher quality resources are available to support the outcomes of the intervention. Ratings are
provided by independent external reviewers who report on six criteria based on a 0.0 – 4.0 scale. The criteria are reliability of measures, validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, and appropriateness of analysis.

8. Program Weaknesses: Each program was reviewed and compared against the requirements of The Center’s SGP grant; weaknesses of each program, if any, were noted.

Note that details of the various interventions are explicated in the Intervention Summary section of the NREPP website under the name of each program, and these were the details used for the comparison.
Table 1

Review of Evidence-Based Interventions that Address Domestic Violence

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Population served</th>
<th>Target behavior</th>
<th>Age served</th>
<th>Length of training</th>
<th>Cost of training</th>
<th>Program length</th>
<th>Rating* (0.0-4.0)</th>
<th>Program weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Alcohol Screening and Intervention for College Students (BASICS)</td>
<td>College students</td>
<td>Excessive alcohol use</td>
<td>18-25</td>
<td>1-3 days</td>
<td>$4000 to $12,000</td>
<td>&lt; 1 day</td>
<td>3.9</td>
<td>Population served; primary focus; age range; cost; school-based</td>
</tr>
<tr>
<td>Celebrating Families! (CF!)</td>
<td>Parents in recovery</td>
<td>Substance use; DV</td>
<td>Parents</td>
<td>2 days</td>
<td>$1500 to $4000</td>
<td>16 weeks</td>
<td>3.6</td>
<td>Population served; primary focus; age range</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population served</td>
<td>Target behavior</td>
<td>Age served</td>
<td>Length of training</td>
<td>Cost of training</td>
<td>Program length</td>
<td>Rating* (0.0-4.0)</td>
<td>Program weaknesses</td>
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<tr>
<td>Child-Parent Psychotherapy (CPP)</td>
<td>Parents and young children</td>
<td>PTSD; attachment disorder</td>
<td>0-5</td>
<td>1-1.5 years</td>
<td>$3000 to $9000+</td>
<td>1 year</td>
<td>3.6</td>
<td>Population served; primary focus; training; cost; length</td>
</tr>
<tr>
<td>Children in the Middle (CIM)</td>
<td>Divorcing families</td>
<td>Parental conflict</td>
<td>only</td>
<td>1 day</td>
<td>$250 to $500</td>
<td>10 weeks</td>
<td>2.3</td>
<td>Rating; primary focus; population served; age range</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population served</td>
<td>Target behavior</td>
<td>Age served</td>
<td>Length of training</td>
<td>Cost of training</td>
<td>Program length</td>
<td>Rating* (0.0-4.0)</td>
<td>Program weaknesses</td>
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<tr>
<td>Cognitive Behavioral Intervention for Trauma in School (CBITS)</td>
<td>Children in school</td>
<td>PTSD; behavior problems; depression</td>
<td>6-12</td>
<td>2 days</td>
<td>$4000</td>
<td>13-15 sessions</td>
<td>3.8</td>
<td>School-based; age range; cost of training</td>
</tr>
<tr>
<td>Curriculum-Based Support Group (CBSG)</td>
<td>At-risk youth</td>
<td>Future substance use</td>
<td>6-12</td>
<td>2 days</td>
<td>$300</td>
<td>10-12 weeks</td>
<td>3.7</td>
<td>Population served; primary focus</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population served</td>
<td>Target behavior</td>
<td>Age served</td>
<td>Length of training</td>
<td>Cost of training</td>
<td>Program length</td>
<td>Rating*</td>
<td>Program weaknesses</td>
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<tr>
<td>Dialectical Behavior Therapy (DBT)</td>
<td>Adults</td>
<td>Psycho-social maladjustment</td>
<td>18-55+</td>
<td>10 days</td>
<td>$2400</td>
<td>Ongoing</td>
<td>3.2</td>
<td>Population served; cost; age range; program length</td>
</tr>
<tr>
<td>Helping Women Recover and Beyond Trauma</td>
<td>Women in correction facilities</td>
<td>Substance use; trauma</td>
<td>26-55</td>
<td>2 days</td>
<td>$4000 to $10,000</td>
<td>17 weeks</td>
<td>3.3</td>
<td>Population served; cost of training; age range</td>
</tr>
<tr>
<td>Moral Reconciliation Therapy</td>
<td>Criminal offenders</td>
<td>Criminal behavior and attitude</td>
<td>13-55</td>
<td>5 days</td>
<td>$600</td>
<td>3-6 months</td>
<td>2.9</td>
<td>Length of treatment; rating; population served</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population served</td>
<td>Target behavior served</td>
<td>Age served</td>
<td>Length of training</td>
<td>Cost of training</td>
<td>Program length</td>
<td>Rating* (0.0-4.0)</td>
<td>Program weaknesses</td>
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<tr>
<td>Parenting with Love and Limits (PLL)</td>
<td>Children and their families</td>
<td>Severe emotional/behavioral problems</td>
<td>6-17</td>
<td>5 days + follow-up</td>
<td>$1500 per family sessions</td>
<td>4-20</td>
<td>3.8</td>
<td>Population served; cost of training; target behavior</td>
</tr>
<tr>
<td>Partners with Families and Children: Spokane</td>
<td>Parents of young children</td>
<td>Child neglect and abuse</td>
<td>0-30</td>
<td>1 day</td>
<td>$350</td>
<td>6-12</td>
<td>2.1</td>
<td>Population served; length of treatment; rating</td>
</tr>
<tr>
<td>Seeking Safety</td>
<td>Teens and adults</td>
<td>Substance use; PTSD</td>
<td>13-55</td>
<td>1-2 days</td>
<td>$1600+</td>
<td>**</td>
<td>4.0</td>
<td>Population served; cost; age range</td>
</tr>
<tr>
<td>Intervention</td>
<td>Population served</td>
<td>Target behavior</td>
<td>Age served</td>
<td>Length of training</td>
<td>Cost of training</td>
<td>Program length</td>
<td>Rating* (0.0-4.0)</td>
<td>Program weaknesses</td>
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<tr>
<td>Trauma-Recovery and Empowerment Model (TREM)</td>
<td>Women exposed to abuse PTSD; depression</td>
<td>18-55</td>
<td>2 days + follow-up</td>
<td>$4000 to $9000</td>
<td>24-29 sessions</td>
<td>3.4</td>
<td>Population served; length of treatment; cost of training</td>
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<tr>
<td>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</td>
<td>Victims of DV + Parent PTSD; anxiety; depression</td>
<td>0-55</td>
<td>10 hours; 2 days +</td>
<td>$495</td>
<td>8-16 sessions</td>
<td>3.7</td>
<td>Potential cost of training</td>
<td></td>
</tr>
</tbody>
</table>

* Dissemination readiness, including: Implementation materials; training and support; quality assurance (Based on NREPP guidelines)

**Information unavailable**
**Evaluation**

The first column of Table 1 lists the 14 interventions that were reviewed. These are: Brief Alcohol Screening and Intervention for College Students (BASICS); Celebrating Families! (CF!); Child-Parent Psychotherapy (CPP); Children in the Middle (CIM); Cognitive Behavioral Intervention for Trauma in School (CBITS); Curriculum-Based Support Group (CBSG); Dialectical Behavior Therapy (DBT), Helping Women Recover and Beyond Trauma; Moral Reconation Therapy; and Parenting with Love and Limits (PLL). Each intervention was assessed based on the eight guidelines listed across the top of the table, such as target population and cost of training. They were compared against the criteria of SGP and those features that weren’t in line with the needs and goals of SGP were placed in the last column, such as age range and length of training.

As the last column in Table 1 illustrates, there are numerous “Weaknesses” in nearly all the programs that prohibit them from being viable candidates for the Second Generation Project. For example, the population that SGP serves are child victims of domestic violence; however, programs such as CF!, CIM, DBT, Helping Women Recover, and TREM serve adult men or women, and Moral Reconation Therapy serves criminal offenders. The target behaviors of SGP are PTSD, trauma, depression, and negative behavior patterns; however, the behavior targeted in BASICS, CF!, and CBSG is substance use. The age range of SGP’s child clients is 3-18 years; however, the age range of BASICS, CF!, DBT, CIM, Helping Women Recover, and TREM is 18 and above. Because of the limited time frame outlined in the SGP grant for project implementation, it is hoped that the length of facilitator training for SGP will be minimal;
however, the length of training required to implement CPP, for example, is 1-1½ years. The SGP grant provides limited funding for training; however, the cost of training for programs such as CPP, PLL, and TREM is prohibitive.

Since families often remain at the shelter for no more than 8-12 weeks, dissemination of the SGP curriculum must be time-limited; however, programs such as Partners with Families and Children and CPP can require up to one year of a participant’s commitment. The NREPP rating, on a scale of 0.0 to 4.0, evaluates the dissemination readiness of each program. Factors such as training, support, and quality assurance are evaluated. I determined that a score of 3.0 or above was preferable; however, CIM received a rating of 2.3 from the NREPP, and Partners with Families and Children received a rating of 2.1.

Note that, in addition to the 14 interventions listed by the NREPP for domestic violence, a review was conducted of five additional promising interventions prevalent in the research literature and/or used by professional clinicians in the community: Positive Parenting Program (Triple-P) (Sanders, 2008); the Neurosequential Model of Therapeutics (NMT) (Perry & Hambrick, 2008); Abuse-Focused Cognitive Behavioral Therapy, or Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) (Kolko & Swenson, 2002); Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2001); and Parent-Child Interaction Therapy (PCIT) (Bagner, Boggs, & Eyberg, 2010); however, based on the eight guidelines established to review the interventions, none of them were determined to be appropriate for the Second Generation Project.
Based on the program review, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) appeared to be the most appropriate therapeutic intervention to implement at The Center. The population that TF-CBT serves is child victims of domestic violence and their non-offending parents. The intervention focuses on depression, PTSD, anxiety, and trauma symptomology, and it serves individuals between ages 0-55. Clinicians can learn the fundamentals of TF-CBT in 10 online training hours and acquire certification in approximately 16 hours. It is recommended that TF-CBT be implemented over the course of 8-16 sessions and it received an NREPP rating of 3.7 out of 4.0.

The potential weakness of TF-CBT was the cost of facilitator training, as the SGP committee had not yet determined what portion of grant monies would be allocated for training. As it turned out, the initial 10-hour online training was free and the 2-day certification training was $495 plus airfare and lodging, a reasonable sum compared to the cost of other program trainings.

Another indicator that Trauma-Focused Cognitive Behavioral Therapy was a viable intervention was its evidence-based pedigree. A search for TF-CBT was conducted on the California Evidence-Based Clearinghouse for Child Welfare (CEBC) website. It was listed under Trauma Treatment, Child & Adolescent; Anxiety Treatment, Child & Adolescent; and Sexual Behavior Problems in Children. The CEBC awarded TF-CBT a 1 on its Scientific Rating Scale (“Well-Supported by Research Evidence”) and a 1 on its Relevancy Scale (“High”). In fact, of the CEBC’s 206 programs, TF-CBT was
the only program with a score of 1 on both of its rating scales, the highest score awarded by the CEBC to child welfare interventions.

For further assurance that TF-CBT was endorsed by reputable sources, a search was conducted on the American Psychological Association (APA) website. The APA maintains 56 divisions, which are interest groups comprised of members with common interests in either a subdiscipline such as clinical psychology or a topical area such as trauma. The website for Division 12, the Society of Clinical Psychology, lists 15 disorders, provides a description of each, and offers recommended psychological treatments along with the varying degrees of research support for each intervention. One of the disorders listed is post-traumatic stress disorder (PTSD). For PTSD, which is frequently observed in child victims of DV (Hunt, Martens, & Belcher, 2011; Jarvis, Gordon, & Novaco, 2005; Kilpatrick & Litt, 1997; Margolin & Vickerman, 2007), Division 12 defers to Division 53, the Society of Clinical Child and Adolescent Psychology (SCCAP). SCCAP, in collaboration with the Association of Behavioral and Cognitive Therapies (ABCT), lists TF-CBT as the only “well-established” evidence-based protocol for the treatment of child and adolescent PTSD (Society of Clinical Child and Adolescent Psychology, 2010). “Well-established” treatments are considered to meet the guidelines for the strongest research support to date; they must satisfy stringent criteria, including superior efficacy in at least two large-scale randomized control trials (Association of Behavioral and Cognitive Therapies, 2010).
Adaptation of TF-CBT for the Second Generation Project

Although TF-CBT is one of the most appropriate evidence-based practices for The Center’s program, it is not a pre-packaged, ready-made, “turn-key” product. There were specific requirements and goals outlined in the grant that The Center had to meet in order to implement the program and provide for its sustainability (see Chapter 3). TF-CBT addressed many of the goals; however, its portability was critical. In other words, fidelity to the intervention had to be maintained even as adjustments were made so that the final curriculum (a) addressed the four primary goals of the grant, (b) was adjusted to serve an age range of 3-17, (c) was shortened to accommodate an 8-week format, and (d) was modified for use in a group environment rather than in individual therapy. In addition, elements of other programs were added to the curriculum to more thoroughly encompass the goals of SGP. For example, an opening and closing ritual was put in place during each session to engender a sense of safety and routine for the participants.

Goals of TF-CBT

An issue brief published by the U.S. Department of Health & Human Services/Administration for Children and Families about TF-CBT outlines the intervention’s key components, target population, degree of effectiveness, and so on. It states that the general goals of TF-CBT are:

[to] reduce children’s negative emotional and behavioral responses to … abuse, correct maladaptive or unhelpful beliefs and attributions related to the abusive experience … provide support and skills to help non-offending parents cope effectively with their own emotional distress, [and] provide non-offending parents
with skills to respond optimally to and support their children. (Child Welfare Information Gateway [CWIG], 2007, p. 4)

Additionally, the National Child Traumatic Stress Network (NCTSN, 2004) reports that, while TF-CBT primarily reduces symptoms of PTSD such as intrusive thoughts, upsetting memories, hyperarousal, irritability, emotional numbing, and isolation, it can also result in improvements in “depression, anxiety, behavior problems, sexualized behaviors, trauma-related shame, interpersonal trust, and social competence” (p. 9).

With regard to the third goal of the grant, parenting training, the NCTSN reports that TF-CBT is effective in helping parents to (a) overcome general feelings of depression, (b) reduce PTSD symptoms, (c) reduce emotional distress about the child’s trauma, (d) improve parenting practices, and (e) enhance their ability to support their children (2004, p. 10).

**Developers of TF-CBT**

Research studies on the efficacy of TF-CBT have been conducted since the late 1980s. The treatment protocol was originally designed to reduce negative emotional and behavioral responses following child sexual abuse; however, continuing research studies have indicated that it is appropriate for a variety of child traumas, including the loss of a loved one, domestic and community violence, accidents, hurricanes, and terrorist attacks (Child Welfare Information Gateway [CWIG], 2007). The original developers of TF-CBT continue to be involved in ongoing research. The three original developers of TF-CBT are Judith Cohen, M.D., Medical Director of the Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital; Esther Deblinger, Ph.D., Co-
founder/Co-director of the CARES (Child Abuse Research Education and Service) Institute, University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine; and Anthony Mannarino, Ph.D., Director of the Division of Child and Adolescent Psychiatry, Allegheny General Hospital. Along with Dr. Judith Cohen, Drs. Mannarino and Deblinger are affiliated with Allegheny General Hospital’s Center for Traumatic Stress in Children and Adolescents (CTSCA) based in Pittsburgh, PA (Center for Traumatic Stress in Children and Adolescents, 2010).

**Needs Assessment Tools for Child and Parent Clients**

Assessment tools were selected or created in order for therapists to accurately determine the suitability of a child for participation in SGP. Not all children are a good fit for such a program. TF-CBT is not recommended for children whose predominant problems are, for example, “disruptive behaviors such as defiance, disobedience, aggression, rule- or law-breaking” (National Child Traumatic Stress Network [NCTSN], 2004, p. 10). In addition, severely depressed or suicidal children, or those who have active substance abuse issues, should receive treatment that is specific to their conditions (NCTSN, 2004).

Various assessment tools have been used in other settings to assess a client’s appropriateness for TF-CBT (NCTSN, 2007). They include the following:

1. An initial clinical interview with parent and child
2. Kiddie-SADS structured interview
3. Children’s Depression Inventory
4. State-Trait Anxiety Inventory for Children
5. Child Behavior Checklist

6. Child Sexual Behavior Inventory

7. Children’s Attributions and Perceptions Questionnaire

8. Parent’s Emotional Reaction Questionnaire

9. Parental Support Questionnaire

10. Parenting Practices Questionnaire

11. Beck Depression Inventory (for parental depression)

12. UCLA PTSD Index for DSM-IV

Other viable assessment tools include the Domestic Violence Questionnaire (Wahl, Sisk, & Ball, 2004) and the Child Trauma Screening Questionnaire (Kenardy, Spence, & Macleod, 2006).

One of the assessment tools recommended by two certified TF-CBT trainers (Hendricks & Rose-Walsh, personal communication, November 4, 2010) was the UCLA PTSD Index for DSM-IV, Revision I (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998). It is available in three versions: Child Version, Adolescent Version, and Adult Version. One of the assessment’s authors, Robert Pynoos, M.D., is a professor of psychiatry in the UCLA Department of Psychiatry and Behavioral Sciences, co-director of the National Center for Child Traumatic Stress, and director of the Trauma Psychiatry Service at UCLA Health System. Dr. Pynoos was contacted via e-mail for permission to use the inventory for this project, and permission was granted.

In addition to the UCLA PTSD Index, other assessment tools, consent forms, and documents were compiled for use in both the Child Client File (see Appendix C) and the
Parent Client File (see Appendix D). The Authorization for Exchange/Release of Information form, Domestic Violence Assessment, Parent Shelter Resident Intake form, and statistical record-keeping sheet were forms The Center had on file for use with its clients. The progress notes and client log were created by this author. Various marriage and family therapists who had experience with children and/or trauma were consulted about the Child History Intake Form, Informed Consent Agreement, and Symptom Checklist. Templates used by the practicing clinicians were synthesized into three unique documents that addressed the specific needs of the child population at The Center’s shelter.

In order to get a more thorough picture of the child’s background, the 4-page Child History Intake Form is to be filled out by the non-offending parent, with assistance from the therapist as needed. It contains questions about the child’s education, medical background, domestic violence history, and various behavioral problems/characteristics/strengths. Information about family pets is also solicited, such as whether or not the offending parent or the child has ever hurt or threatened to hurt a family pet.

The 1-page Symptom Checklist is to be filled out by the non-offending parent about the child. It assesses symptomology in three areas: (a) Physical challenges, such as poor appetite, self-injury, or eating disorders; (b) School challenges, such as declining grades, poor memory, or bullying incidents; and (c) Interpersonal challenges, such as poor social skills, mistrust of adults, or a desire to see the offending parent.
The Informed Consent agreement is for the mother to sign on behalf of herself and her child(ren). It outlines the therapy process, benefits of counseling, and limitations of confidentiality. The Domestic Violence Assessment solicits information about the verbal, emotional, sexual, and physical abuse the mother has experienced in the past. The Parent Shelter Resident Intake Form solicits information about the offending parent, the history of abuse, medical injuries, legal proceedings, weapons use, family history of abuse, and past use of social services. Finally, although they were not part of the expert evaluation because they are standard forms, the Authorization for Exchange/Release of Information Form, client log, blank progress notes, and a statistical record-keeping sheet were included in the files. See Table 2 for a complete list of documents.
Table 2

*Contents of Client Files*

<table>
<thead>
<tr>
<th>Child Client File</th>
<th>Parent Client Filea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed Consent Agreement</td>
<td>Informed Consent Agreement</td>
</tr>
<tr>
<td>Child History Intake Form</td>
<td>Parent Shelter Resident Intake Form</td>
</tr>
<tr>
<td>Symptom Checklist</td>
<td></td>
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<tr>
<td>UCLA PTSD Index for DSM IV, Child Version</td>
<td>Domestic Violence Assessment</td>
</tr>
<tr>
<td>Authorization for Exchange/Release of Information Form</td>
<td>Participation in SGP Agreement</td>
</tr>
<tr>
<td>Blank progress notes</td>
<td>Blank progress notes</td>
</tr>
<tr>
<td>Client log</td>
<td>Client log</td>
</tr>
<tr>
<td>Statistical record-keeping sheet</td>
<td>Statistical record-keeping sheet</td>
</tr>
</tbody>
</table>

aNot included in the Curriculum Packet

**Curriculum Development**

**TF-CBT Training**

To learn more about TF-CBT, an online training class called *TF-CBT/Web*, A web-based learning course for Trauma-Focused Cognitive-Behavioral Therapy is available free of charge through the Medical University of South Carolina’s National Crime Victims Research and Treatment Center (Saunders & Smith, 2005). It includes lessons, video examples, facilitator scripts, and quizzes on topics such as Psychoeducation, Stress
Management, Affect Expression and Modulation, Cognitive Coping, and Parent-Child Sessions. It takes approximately 10 hours to complete. The 10-hour online course is a valuable prerequisite for various 1-to-3 day TF-CBT training sessions that are periodically scheduled in cities across the nation (Cohen & Mannarino, 2008.)

In order to learn more about TF-CBT in preparation for the curriculum development, I completed the 10-hour online course. I was then given approval by the SGP committee to attend a two-day training in San Diego, CA called Trauma-Focused Cognitive Behavioral Therapy Training and Consultation, sponsored by the Chadwick Center for Children & Families, an affiliate of Rady Children’s Hospital in San Diego. Goals of the training included the following:

1. Learn about TF-CBT for children who have experienced trauma.
2. Be able to identify appropriate cases for TF-CBT.
3. Increase skills for assessing trauma history and symptoms.
4. Improve clinical skills in implementing the eight treatment components that comprise the PRACTICE acronym.
5. Identify cultural factors that impact treatment.
6. Identify benefits of direct discussion of traumatic events.
7. Learn about vicarious trauma and self-care techniques.
8. Network with peers to form a collaborative learning environment. (Hendricks & Rose-Walsh, 2010)

Practitioners who attended the training were required to attend at least 10 of 12 follow-up 1-hour consultation conference calls with one of the training’s facilitators in
order to receive a Certificate of Completion. My schedule allowed me to participate in all twelve follow-up calls. The San Diego training cost $495.00 plus transportation and lodging; the follow-up consultation calls were free of charge.

**The “PRACTICE” Protocol**

The protocol components of TF-CBT are summarized by the acronym “PRACTICE”, which denotes the following:

- **P** – Psychoeducation and Parenting Skills: Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions; Parenting skills are taught to optimize the child’s emotional adjustment.

- **R** – Relaxation Techniques: Stress management skills are individualized for both the child and parent.

- **A** – Affective Expression and Modulation: A variety of feelings are identified to help child cope with a range of emotions.

- **C** – Cognitive Coping and Processing: The relationships among thoughts, feelings, and behaviors are illustrated to help child and parent modify unhelpful thoughts.

- **T** – Trauma Narrative: The child describes his/her personal traumatic experiences to the parent.

- **I** – In vivo Mastery of Trauma Reminders: Child overcomes avoidance of situations that are not dangerous but act as trauma reminders.

- **C** – Conjoint Parent/Child Sessions: Child and parent come together to discuss child’s trauma narrative.

Since there are eight protocol components of TF-CBT, each of the eight curriculum sessions was developed around one of these components. For example, session one (“P”) focuses on Psychoeducation and session two (“R”) focuses on Relaxation. The format of each session is listed in spreadsheet fashion, and a minute-by-minute account of activities is listed under the following table headings: Topic, Minutes, Topic Objectives, Content, Delivery Approach, Activities, Materials, and Adaptations (See Appendix E).

Lesson plans were developed that use a combination of learning modalities such as discussion, hands-on activities, lecture, and storytelling. These were included to accommodate the various learning styles of the participants. In addition, the therapist implementing the program will be prepared to modify aspects of each session as needed for children with special needs, such as procuring an interpreter for a monolingual participant or providing adequate space for a child in a wheelchair.

It was important to be sensitive to the needs and schedules of the program participants. It was assumed that, upon entering the shelter, some of the women would be employed part- or full-time and that all of the children would be in school, or – if their old residence was in a school district beyond the shelter’s neighborhood – they would be in the process of registering at a local school. Therefore, it was determined that sessions would take place in the early evening on weekdays and on weekend mornings.
**Curriculum Facilitators**

Individuals qualified to implement TF-CBT include licensed marriage and family therapists and licensed clinical social workers. To that end, the Second Generation Project grant budgeted $10,000.00 for each year of the 3-year program to hire a part-time licensed practitioner (MFT or LCSW) who possesses the following: expertise in facilitating children’s groups, preferably for children who are victims of domestic violence or sexual assault; a commitment to the issues of domestic violence; strong organizational skills; supervision experience; a willingness to work afternoons and/or evenings and weekends; and the ability to work as a member of a team, among other qualifications (J. Knapp, personal communication, September 15, 2010). Note that, during the course of this project, no suitable clinician was employed to implement the curriculum; however, hiring efforts were undertaken by The Center’s SGP committee to procure one.

**Program Components**

The following components of the program were established in order to assess the clients, fulfill the grant requirements, respect the time schedules of the participants, maximize the effectiveness of TF-CBT in a group format, respect the confidentiality of the children’s personal stories, and maintain a time-frame of eight weeks:

1. A licensed clinician will complete a thorough intake assessment of mother and child(ren).
2. A customized Goals and Needs list will be completed for each participant.
3. Implementation of TF-CBT will be in the form of an 8-week group curriculum.
4. Children will attend one 90-minute group session and one 45-minute individual session each week.

5. Mothers will attend one 15-minute individual session each week.

6. Each week, an aspect of TF-CBT’s “PRACTICE” acronym will be addressed in the group sessions and homework will be assigned.

7. Individual child sessions will consist of a check-in, a review of homework/skills learned in the previous group session, and a review of the Goals and Needs list.

8. Individual parent sessions will consist of a check-in, skill-building for parent/child effectiveness, and helpful handouts.

9. Creating a Personal Story (Trauma Narrative) is a critical aspect of TF-CBT but should not be done in a group format. Therefore, it will be created in the child’s individual sessions 4, 5, and 6. In session 7, the child will share the narrative with his/her mother.

It is important to emphasize that, because the curriculum is time-limited, it is NOT expected that the child’s therapeutic experience will be intense and exhaustive. Instead, it will consist of skill-building and the sharing of a story.

**Program Format**

**Group Sessions.** The group sessions will be led by a licensed practitioner and assisted by several facilitators who are trained volunteers from The Center and/or are graduate level psychology/social work interns. During the group sessions, participants will learn about concepts such as relaxation, breathing, the expression of feelings, the cognitive triangle, safety issues, boundaries, positive thinking, and mindfulness. They
will participate in group activities and Brain Gym (Dennison & Dennison, 1992), which is a program that enhances learning through physical movement. There will also be story-telling and group discussions. Each session will include a 10-minute snack break and homework will be assigned that consists of fun handouts and illuminating texts.

**Individual Sessions.** The 45-minute individual child sessions will take place each week and be conducted by a licensed practitioner. Each session will consist of a check-in, skill-building, and a review of the child’s customized Goals and Needs list. During session #4, the child will be invited to start creating a short personal story, or Trauma Narrative. The child will be able to express his/her personal story as a poem, journal, song, collage, written narrative, or in any other unique and creative way the child so chooses. The goal of this story will be to “unpair thoughts, reminders, or discussions of the traumatic event (i.e., the domestic violence) from the overwhelming negative emotions such as terror, horror, extreme helplessness, or rage” (Hendricks & Rose-Walsh, 2010, p. 2). Once the story is complete, the licensed practitioner will assist the child by correcting cognitive distortions about the event and modeling adaptive coping. According to Rose-Walsh, “Trauma can come to define a child’s life – we want it to only be an integrated part of his or her totality” (personal communication, November 4, 2010).

**Parent Sessions.** The 15-minute individual parent sessions will take place each week and be conducted by the licensed practitioner. The mother will share a check-in about her week and she will receive information about parent effectiveness and stress-reduction techniques. Additionally, the licensed practitioner (with the child’s permission) will provide updates to the mother about the child’s developing personal story. At week
7, the goal of the conjoint session will be to have the child share the story with his or her mother. This feature of the curriculum is paramount: because the curriculum is time-limited and the participants are transient, this conjoint session of personal story-telling will help to establish the mother as a critically important individual in the child’s life; one to whom the child can turn in the future to communicate thoughts, feelings, and concerns.

**Program Evaluation**

Two evaluation tools, to be completed by the shelter clients, were developed for the program: a pre-test/post-test and a program evaluation form (see Appendix F).

**Pre-test/Post-test.** The first evaluation is a pre-test/post-test that addresses Kirkpatrick’s (1994) second and third levels of evaluation, Learning and Behavior. It was developed to provide The Center with feedback about the participants’ skill-building mastery. The pre-test will be administered to the child during the initial assessment phase of the program and will establish a baseline of knowledge and skills. The post-test will be administered during the eighth and final individual session. It will evaluate the child’s skill-building mastery, knowledge the child has acquired over the course of the program, and new behaviors the child has learned. Note that mothers will not take the pre-test/post-test.

**Program Evaluation Form.** The second evaluation tool addresses Kirkpatrick’s first level, Reaction. It will provide The Center with feedback about each participant’s subjective opinion of the program and assist in determining the program’s overall effectiveness. Both the parent and the child will fill this out during the eighth and final individual session. It will provide The Center with feedback about aspects of the
program in which the child participated, such as activities, lectures, discussions, individual sessions, and so on. Note that the mothers will fill out a separate program evaluation form during the final individual session that addresses activities, sessions, and issues of interest.

**Expert Evaluators**

Prior commitments prevented several evaluators from completing and returning their forms in a timely manner but, of the 14 curriculum packets distributed to the expert evaluators who consented to participate in the evaluation, a total of 11 evaluations were eventually received over a period of three months. Most evaluators completed a majority of the form, and all of them offered comments, suggestions, and criticisms in the last section of the form, which solicited final personal thoughts about the program. In addition, it should be noted that two of the three original co-developers of Trauma-Focused Cognitive Behavioral Therapy were contacted and agreed to act as expert evaluators for this project. Their input was generous, their appraisals were insightful, and their suggestions provided a critical and unique perspective with regard to the goals of this project.

**Expert Evaluations**

Responses to 18 open-ended questions in the three areas of (a) Child Client File, (b) Curriculum, and (c) Evaluation Methods, along with additional comments, were collated and summarized. I received roughly 11 responses for each question and collected them into 18 groups of 11. I then searched for themes in each group, which I discussed in summary form. Note that, although the themes indicated there was a
consensus of sorts among the evaluators and there was value in that, I did not have a large enough sample size to do a quantitative analysis, so I was careful to include responses and suggestions shared by individual evaluators, as well. I also determined that most of the positive feedback did not have to be reported because it merely confirmed viable aspects of the existing program. It was more important to make note of criticisms and suggestions, as it is from this material that improvements to the program will be made. Feedback included opinions in areas such as feasibility, thoroughness, program fidelity, appropriateness, participants, objectives, ethics, time-frames, and goals.

**Child Client File**

Although there were no major objections to the documents contained in the child client file, several constructive suggestions were offered by the evaluators about them.

**Informed Consent.** Several evaluators reported that the curriculum’s Informed Consent form was fine as it stood; however, others offered suggestions to make it more thorough and informative. One evaluator stated it should include more details about the phenomenon of child abuse and contain information about the Tarasoff ruling; that is, “A mental health professional has a duty not only to a patient, but also to individuals who are specifically being threatened by a patient” (Tarasoff v. Regents of the University of California, 2011, para. 7; see also Ewing, 2005). Another mentioned that state laws differ with regard to who can sign a child into treatment if the child’s parents are divorced, so California family law statutes should be reviewed. There were concerns about making sure the form explicated not just the rewards but the risks of treatment. One evaluator said, “It is conventional that informed consent procedures list the major
risks associated with treatment, including the risk of no effect and negative effects. Since all treatments have such risks, information probably should be provided on these risks and any limiting conditions.”

**Child History Intake Form.** In general, the form was reported to be “very good and comprehensive,” but there were suggestions made to better target specific behaviors. For example, instead of asking if the child “has difficulty going to school,” the form should ask if the child is avoiding school, skipping school, getting suspended, and so on. The section about the child’s medical status should include questions about the child’s sleep habits, appetite, and drug/alcohol use. Questions about learning disabilities should be moved to the Education section. One evaluator suggested the term “offender” be taken out of the intake form: “Many times, the offender is a family member and if you began by stating ‘offender’, it would create a gap between you and the client.” The therapist conducting the assessment should also keep in mind that “sometimes both parents are offenders.”

In the Domestic Violence History section, questions about whether a child has witnessed domestic violence should include specific examples to which he/she can respond so that a clear picture of what the child has experienced can be created for the therapist. A question about whether there is access to weapons in the home or community should also be added to the Domestic Violence History section, and inquiries should be made “about other types of trauma, as most children have a history of multiple traumas.” One evaluator suggested that the form include questions about attachment with
caregivers, stating “This will better help with knowledge of emotional tools and capacities contained within the individual before even trying to reprocess the trauma(s).”

**Symptom Checklist.** It was suggested that, instead of listing the combined phrases “Cannot sleep/Prefers to sleep with mother,” the two issues be separate inquiries on the Symptom Checklist. Also, nightmares and bedwetting should be added to the list of Physical Challenges and “bullies other kids” should be added to School Challenges.

**General comments.** When asked if the documents contained in the child file were adequate assessment tools for qualifying a child to participate in the program, most evaluators said “yes.” However, there was concern that it was “overwhelmingly geared to obtaining information from the perspective of the parent.” It was also suggested that throughout the program the therapist monitor each child’s symptoms and fill out a symptom tracking checklist for each one. Evaluators suggested that the UCLA PTSD Index for DSM-IV (Adolescent Version) and the UCLA PTSD Index for DSM-IV (Adult Version) be added to the file, as well as a parent rating instrument such as the Child Behavior Checklist. The following concern was articulated: “If the PTSD Index is given to a child prior to treatment, be aware that it will be very triggering to the child and they will need help processing. I would not recommend this in the first interview.” It was also noted that the way the sexual abuse question on the PTSD Index is worded does not adequately address the issue of sexual abuse.

Several evaluators wondered if the potentially young ages of some of the children, or certain behaviors such as hyperactivity, might make it difficult to solicit the information required. They inquired about the reading level of both the children and
mothers, and wondered whether provisions had been made in case the mother or child did not speak English. Finally, in response to whether the client file provided adequate tools for an assessment, one evaluator said, “No, but it is adequate for a standard intake screening. Assessment implies in-depth clinical interviewing and application of standardized measurements.”

**Curriculum – Group sessions**

Questions regarding the curriculum constituted the largest segment of the evaluation form. There were three questions about the overall structure of the curriculum, eight questions about the group sessions, and three questions about the individual sessions. The form’s questions are listed below along with the various responses offered by the evaluators.

**Do the Session Topics satisfy the Session Objectives in each session?** A majority of evaluators said the topics listed for each session satisfied the session’s objectives, and one commented that the curriculum was “very well done and very comprehensive.” Several evaluators suggested that curriculum modifications be in place and available to accommodate different ages, as well as to accommodate children and teens of different cognitive or developmental levels. One evaluator determined that a 90-minute group session was too long, especially for younger children, and that there were too many activities in each session. She suggested the sessions last 45-60 minutes instead of 90 minutes. Additionally, a critical component of TF-CBT is gradual exposure and, although an evaluator acknowledged that it is difficult to include in group therapy, he noticed it was not included in most sessions but should be.
Do the topics address the protocols contained in TF-CBT’s “PRACTICE” acronym? In response to whether or not the topics addressed the “PRACTICE” protocols, there was general agreement that they did. As an example, an evaluator stated, “Yes. Given the fact that the sessions are structured to be offered only for 8 weeks, the objectives are addressed reasonably well.” Another said, “Yes – Very creative!” However, one evaluator stated, “They seem to have the same face content, but I don’t know if they address it further than a shared terminology.” Another evaluator, whose area is complex trauma, stated that “the group may need to be extended [to] 16 weeks, two [meetings] per session [topic], depending on the type and severity of trauma. I have a concern that eight weeks for complex trauma or children with significant PTSD would be moving too quickly for them. [However] it may be that you are dealing with less impacted populations. You will probably get an idea when the group process begins.”

Is there an adequate balance of learning modalities to satisfy the various learning styles of the group participants? (e.g., activity, discussion, storytelling, lecture, etc.) The biggest concern reported by the evaluators about the existing format was the potentially wide range of ages in a single group. They thought there was an adequate balance of learning modalities but the activities listed were more appropriate for younger children, not for older children or teens. Several evaluators reported that an explanation of how activities intend to be adapted for various developmental levels should be included in the curriculum. A suggestion was made that “more activities” be emphasized for younger age groups and “more discussion” be emphasized for older age groups. Although one evaluator thought the activities were “excellently conceived to
address the needs of children who have experienced trauma that they shouldn’t experience,” she felt the sessions were “heavy on the therapist-directed conversation” and suggested that “more hands-on experiences” be integrated into the curriculum. In reference to both the children and the mothers, another said that “the more they ‘do’, the better they will ‘get it’.”

**Do session objectives meet the goals of the curriculum?** There are four primary goals of the curriculum:

1. Awareness/Education
2. Skill-building
3. Connection with mother
4. Reduction of trauma symptomology

In the program, 1-3 sessions are dedicated to each goal. The evaluators were asked if the objectives of each session met the session’s overall goals. Sessions 1 and 8 address the first goal of awareness/education.

**Session 1 – Psychoeducation.** There was general consensus that Session 1 satisfies its goals and objectives. It is “well laid out,” “very informative,” contains plenty of active learning, has a nice balance of activities, and “all objectives are represented in didactic and/or activity form.” However, there was concern that the session is too ambitious. It was suggested that “the focus should be on group cohesion and just a little bit of psychoeducation on the TF-CBT model.” Another evaluator said: It starts well with intros and icebreakers and unity development, but then the focus shifts to understanding safety, which is a great topic and should be the only other focus during
this week. [However, following this there is] the introduction of boundaries and then
cultural considerations and respect and then affirmations and homework, etc. It just feels
like there is not a clear focus right from the beginning. When establishing safety in
groups, clinicians need to keep things simple and predictable. The overall structure of the
groups feels appropriate, but there needs to be trimming of the overall content. I know
this is difficult to do in just eight weeks, but these are my suggestions.

It was also mentioned that more domestic violence education take place in this
session as well as information about how to get help from trusted adults. Additionally, an
evaluator commented that “Awareness is somewhat like muscle memory. It is gained
through practice. Please include more awareness-based activities.” Finally, the following
observation was made about all eight sessions of the curriculum:

These sessions are scripted out almost in recipe fashion. Following manuals that
take this approach has sometimes been linked to poor outcomes because the
recipes do not allow for individual differences in patients, parents, and therapists.
Patients tend to perceive highly structured and lock-stepped approaches as lacking
in sensitivity. Thus, the absence of detail on how the process will unfold and be
used poses a real handicap in determining how effective this approach might be or
what dangers it might pose for negative effects.

Session 8 – Enhancing Future Safety and Development. There was general
agreement that the objectives of the session meet the goals of awareness/education. It
contains a “good overview and review” and has a nice focus on safety. One evaluator
claimed that the lesson “did a great job of concrete safety and felt-safety identification”
and shared the following: “I always talk about how you feel unsafe when watching a scary movie, even though you really know you’re safe. It may lead to interesting discussions.” However, as with Session 1, several commented that Session 8 is too ambitious and that the focus of the group should be on “celebration and review of skills learned throughout the course.” An evaluator suggested the following: “I would put all new material before the snack break and keep the rest of the time for review, sharing, and closure.” Another suggested that “the scope of the session [be] broadened to include specific dialogue within the group on shared experiences of the group members and how they process it.” Finally, an evaluator mentioned he could not see the relationship between the curriculum goals and the objectives of Session 8, “except that they both include a statement of purpose within the realm of increasing awareness.” He added that the “relationship of the actual content of the session with the goal of awareness is unclear---the description tells me little about the process of the session which might create awareness.”

Sessions 2, 3, and 4 address the second goal of skill-building.

**Session 2 – Relaxation.** Some evaluators thought Session 2 contained an adequate range of activities for relaxation, stress reduction, and positive affirmations; however, they emphasized that such skills require consistent practice for “true mastery.” It was also reported that “not all skills will work for all kids” and that part of the individual sessions might include a review of the skills that a child thinks will be helpful for him or her. It was suggested that various relaxation and stress reduction exercises be used at the beginning of every group session, and that simpler concepts for relaxation and stress
reduction be used for pre-school children. As with other sessions, it was mentioned that “there just seems to be too much involved in the curriculum. The focus seems divided and the main points may be lost as a result.”

**Session 3 – Affective Expression and Modulation.** Evaluators thought there were strengths in this session, but that it was incomplete because there is more focus and activities on angry feelings, without considering other important feelings such as fear and sadness. It was suggested that various skills be presented with the message, “Do this when …” so that children are able to tap into such skills at the appropriate times. Another suggestion was made to add an additional session with a specific focus:

I believe it would be wise to add an entire session of grounding after the relaxation session because I would guess that many of the children you will have in the group have somatic symptoms, avoidant coping styles, varying degrees of dissociation, and have not been really in their bodies for some time. This is worth a session to do experiential things like mindfulness, mindful eating, a yoga exercise, etc. They will need to be in their body to even recognize the need for modulation, and [have an opportunity to] experience a wide range of feelings.

**Session 4 – Cognitive Coping and Processing.** Evaluators enjoyed the content of Session 4, reporting that there is nice focus on the Cognitive Triangle and that it is “very powerful.” However, it was again reported that there are too many topics for one session because each objective is quite complex, especially for younger children. It was suggested that “a subset of objectives be chosen based on the group’s needs or age” and that, because young children are not able to do mindfulness exercises, they should be
taught simple motor and sensory tasks. It was also suggested that adequate time be devoted to making sure “the difference between thoughts and feelings are clearly understood” by the children. An evaluator who works at a residential facility reported that his clients practice mindfulness every day, and that it might assist the children to participate in a “quick mindfulness exercise more times during the week” in addition to having them do such an exercise at the start of each session as a warm-up.

Session 7 addresses the third goal of making a connection between the child and his/her mother.

Session 7 – Conjoint Child-Parent Session. Evaluators liked this session but with certain caveats. Even though there is a potential for parent-child connection in this and other sessions, evaluators reported that many mothers are “ill-equipped themselves to hear or talk about abuse candidly.” The mother should be adequately prepared to “emotionally support/hold her child’s personal story” so as not to retraumatize him or her. It is a “heavy session” and it was suggested that the child select an activity, such as a brief game, that could be completed after sharing the narrative so that he or she might experience closure and a sense of normalcy. An evaluator noted the session was “very nice” but asked, “What is the plan for the child to retell with mom or expand or get therapy referrals?” Boundary issues were a concern, such as with whom the child might be able to share the story and from whom it should remain private. In addition, the goal of the session is for the mother to listen to her child, so inviting the mother to ask questions during the session might feel intrusive to the child; perhaps the mother could ask a small number of “I wonder …” statements and the child could feel free to respond
to them or not. Note that the term “quiz” is used in the lesson plans and it was suggested that a less frightening term be used for that portion, e.g., “activity.” With regard to overseeing the child’s development of the narrative, an evaluator suggested the following:

There are specific steps in narrative accounts that can be healing. Please include those steps before the children complete the stories as potentially the situation can be exacerbated through over-emphasis on certain areas of the narration at the expense of other areas that could be integral to the therapy.

Finally, it was suggested that the child’s feelings about sharing the story with his/her mother be discussed during individual sessions toward the beginning of the process, since there is “likely to be a sense of protectiveness of one or both parents” in cases of domestic violence.

Sessions 5 and 6 address the fourth goal of reducing trauma symptomology.

**Session 5 – Trauma Narrative Development and Processing.** Evaluators provided an assortment of responses about Session 5. Several made it clear that trauma narrative work should not be done on a group basis. One recommended that the text selected for this session, “Mommy and Daddy are Fighting,” be reconsidered because it might serve as a trauma reminder for some of the children. Another mentioned the facilitators would have to be cognizant of the potential trauma triggers contained in the session’s content. A suggestion was made to introduce the coping skills slated for Session 6 before Session 5, as the latter potentially brings up trauma triggers but does not provide coping tools to deal with them. A researcher expressed the following concerns:
There is currently strong evidence that victims of trauma often get worse when made to “discuss,” “relive,” or review traumatic events. This is true especially if high levels of emotion are aroused. Some very interesting research is now going on focusing on the topic of means of distancing victims from their experiences rather than confronting them with these experiences. I urge you to be very careful with this process because of the inherent dangers involved of secondary sensitization. The methods proposed for Session 5 could have a negative effect on about 20% of the children or their parents, judging by some of the available epidemiology and long term follow-up studies of emotion-arousing procedures. These negative effects are often exacerbated by deep breathing exercises, which seem to also be in use in this study and in this session.

Finally, one evaluator surmised that all the sessions essentially focus on the goal of developing a trauma narrative and that, as long as gradual exposure is used and an “environment that fosters safety around direct discussion” is nurtured, the goal of trauma reduction is viable.

**Session 6 – In Vivo Mastery of Trauma Reminders.** Evaluators suggested that a second psychoeducation session take place to address trauma triggers before the introduction of Session 6. It was also suggested that the facilitator “depersonalize [the situation] by asking in general what would people expect” and provide participants with examples of the actions of other children. Another reported that children must discuss identification of trauma triggers before discussing coping mechanisms for them, and suggested the topic of coping be moved to later in the session. Additionally, there was
confusion about why there was so much content on the topic of fear in this section and not in Session 3 (Affective Expression).

One evaluator commented that Session 6 has “the greatest level of obvious connection between the session goals and the treatment goal of symptom reduction.” He also thought the exercises in this session were useful because they introduce both knowledge challenges and skill challenges. The biggest concern was that, although the session title implies in vivo work, no such work is actually done in the session. (In vivo work involves engaging “parent and child in creating [a] specific desensitization plan to gradually approach [the] feared situation” [Hendricks & Rose-Walsh, 2010]). The evaluator commented that, “I think there may be a misunderstanding as to what in vivo is.”

Curriculum – Individual sessions

In addition to the group sessions, each child will meet weekly with the licensed practitioner for 45 minutes to check in, review skills, discuss “COWS” (Crises of the Week), and so on. Mothers will meet with the licensed practitioner 15 minutes per week to check in and receive feedback from the therapist about effective parenting strategies. Evaluators were asked three questions about the individual session format.

What are your impressions? Several evaluators mentioned there was not an adequate amount of time devoted to the mother, and they wondered if the mother was going to receive individual or group therapy outside of this program. It was stressed that a prominent feature of this population is impaired behavior regulation and that, because “the family or individual has seen so much negative coping and modeling,” more time
should be devoted to behavior management. Additionally, although an evaluator thought this was a good time to address “COWS,” she wondered if the term might be modified from “Crises of the Week” to “Challenges of the week.” Another suggested that, at some point during the first several individual sessions, a partial conjoint session take place to address the results of the PTSD questionnaire. There was concern that, although each child’s readiness for this task will differ, Week 3 was too early to introduce the trauma narrative. An evaluator who has conducted studies on TF-CBT reported that “the end result is not always the development of a trauma narrative.” She surmised that, over the 8-week period, there will most likely be mothers who need to devote their time to learning behavior management skills and children who will need to focus on learning behavioral regulation skills. Finally, another evaluator who is a co-developer of TF-CBT said, “If you have the resources to provide 45 minutes of individual therapy, why are you not providing individual TF-CBT?”

**Do they complement the weekly group sessions?** Most evaluators reported that the individual sessions complemented the group sessions. One evaluator thought they complemented each other for the first four sessions but that, based on her experience with severe abuse and trauma, Session 4 was too early to begin discussion of the trauma narrative. She also wondered what the group facilitators planned to do about differences in pacing; that is, what they would do if several children moved smoothly through the narrative but others “could not go past the PRAC component for a variety of reasons?” Finally, a co-developer of TF-CBT stated, “I actually think this needs to be the other way
around in that the group sessions need to complement the individual sessions, particularly
since the key parts of TF-CBT should be implemented on an individual basis.”

**What would you like to see added to the individual sessions?** A variety of
excellent suggestions were provided by the evaluators, primarily with regard to the
mothers. It was suggested that, because the mother is critical to the success of the child,
the program should provide mothers with more specific psychoeducation and parenting
skills. Mothers should also receive more training for self-regulation and for the
emotional regulation of her child. Additionally, mothers should be coached on how to
support their children so that the children can continue to re-tell their personal narratives
beyond the period of the program, and there should be more time devoted to the mothers,
as 15 minutes is not an adequate amount of time to achieve session goals.

For the child, it was suggested that each session begin and end with emotional
regulation such as relaxation or visualization exercises, that a quick review of the week’s
group session be completed prior to each individual session, and that more gradual
exposure work in the early sessions be done in preparation for the creation of the trauma
narrative and processing. It was also suggested that more sessions focus on improving
the child’s ability to express emotions, concerns, and experiences with his/her mother so
that such communication becomes routine for the relationship.

**Evaluation methods**

The evaluators were asked to respond to two questions about evaluation methods.
There were mixed responses about both the pre-test/post-test and the participant
evaluation form.
Does the Pre-test/Post-test adequately evaluate the skills learned in the group sessions? Several thought the test was fine and suggested no modifications. Others thought it was adequate, but lacking in key areas. One evaluator said it was a good instrument to evaluate feelings, thoughts, and safety, but that it did not directly address trauma symptomology. Another reported it needed more elements specifically related to domestic violence, as DV is “the heart of the curriculum [and] should be included to measure knowledge/skills gained.” It was suggested that the term “test” be removed from the form because it might provoke anxiety in the children about their having to “pass” it, and that it be specified on items #10 and #11 whether or not participants could circle more than one or only one response. Also, it was not clear to some if the test was going to be administered to both the mother and child, or to just the child. Several considered it a weak instrument because the evaluation procedures are “entirely reliant on the face validity of the questions.” Additionally, the items on the test address knowledge but not the acquisition of skills, which is an important objective as well. Finally, an evaluator reported that the test is “weak and needs more redefinition of the concepts … Children are not that detailed in terms of reporting on issues that deeply concern them. Potentially, this instrument contains several opportunities for socially desirable responses.”

Does the Curriculum Evaluation Form solicit the feedback we need to improve the curriculum for future sessions? Several evaluators reported that the curriculum evaluation was fine. One evaluator commented that “as you go through the process you may find that you need to tweak it a bit based on how the sessions go and
what additional feedback you want- but it is a great starting place!” Others had suggestions for improvement. One thought the Likert scale wording was “a bit odd” and another recommended that “Don’t Agree” be placed on the left and “Agree A Lot” be placed on the right. A suggestion was made to ask the following: “What was the hardest session?”, “What was the best session?”, and “Why?” Additionally, depending on the age of the participants, concern was expressed that “some of the questions are maturely written.” Finally, one of TF-CBT’s co-developers said, “This form reads more like a client satisfaction form rather than a curriculum evaluation form. In our research studies, there is no relationship between client satisfaction and outcomes.”
Chapter 6

DISCUSSION

The goal of this project was to research and develop an evidence-based, therapeutic, group curriculum for use with child victims of domestic violence who are living in an emergency shelter. Specifically, the curriculum was to be implemented for children living at an emergency shelter managed by The Center for Violence-free Relationships, a Northern California agency that provides services to victims of domestic violence and sexual abuse. A 3-year, $60,000.00 grant (the Second Generation Project, or “SGP”) was awarded to The Center to develop a program that would initially service shelter residents and then be expanded to provide services to all residents living in El Dorado County. Nearly 20 child-focused, evidence-based, therapeutic interventions were evaluated for suitability for the project, based on eight specific guidelines and four major goals that reflected the requirements of the SGP grant. After evaluating the relative strengths and weaknesses of each intervention, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was selected, as it was the only program to meet the guidelines and goals outlined for the project.

Because TF-CBT is traditionally used by clinicians in individual counseling settings, modifications to the intervention had to be made. The goal of SGP was to conduct the curriculum a) in a group format, b) over a limited period of time (8 weeks), and c) for a diverse range of ages. A curriculum packet was created based on these criteria. Eleven expert evaluators reviewed the curriculum packet, which consisted of client file documents, the curriculum, and program evaluations. They provided feedback,
both positive and negative, by completing and returning a 3-page, open-ended, 18-item questionnaire.

This project has a variety of strengths, not the least of which is the therapeutic void it fills for children in El Dorado County who find themselves victims and/or witnesses of domestic violence. No agency in the county provides similar services and, if it is shown the curriculum has therapeutic relevance, it is possible that agencies in and around El Dorado County will adopt similar curricula for their own clients. The project is based on the systematic selection of an intervention that has scientific and practical efficacy as well as portability. TF-CBT is a well-researched, evidence-based, therapeutic intervention that has been shown to be effective for the PTSD symptomology of child victims of domestic violence. Thorough efforts were made to maintain the integrity and fidelity of the intervention, even as it was modified for use in time-limited group work. Additionally, feedback from the expert evaluation conducted prior to a pilot test of the curriculum provided program developers of the Second Generation Project committee with useful suggestions and advice. This feedback will prompt modifications and improvements to the program so that The Center’s client population might benefit from a well-informed agency service.

Despite the thoughtful and time-consuming effort invested in this curriculum, the project has limitations that should be addressed. First, although a committee was established to develop a curriculum after the SGP grant was funded, the selection of the TF-CBT protocol and the development of the curriculum were essentially made by this author, who is a therapist trainee, along with guidance and input from The Center’s
Director of Education. Recruiting licensed clinicians to participate in the initial decision-making process might have provided more thoroughly researched and circumspect recommendations.

Second, although there is substantial evidence of TF-CBT’s efficacy in traditional therapeutic settings (American Academy of Child & Adolescent Psychiatry, 2010; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Deblinger, 1996, 2010; Cohen, Mannarino, & Iyengar, 2011; Virginia Commission on Youth, 2011), there has thus far been little research conducted in community settings using small-group or time-limited formats (see Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). In order to adapt the curriculum to the unique circumstances of a domestic violence shelter, modifications to the TF-CBT protocol were made. Granted, a certain degree of portability is essential for any evidence-based practice to be useful in various real-world settings (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001), but it is possible that the efficacy of TF-CBT was compromised in an effort to modify and adapt it for the shelter’s residents. Third, these modifications have not yet been pilot-tested in the community to determine their effectiveness, so conclusions cannot be made about the curriculum as it presently stands.

Additionally, 11 experts participated in the curriculum evaluation and I cannot be certain whether or not it is a sufficient number of individuals to provide feedback that is adequately thorough, diverse, and well-represented. The experts approached the material from a variety of different therapeutic disciplines, but it is not certain whether I might have received additional and novel input had more professions been represented. Finally,
although the feedback I received was generous and insightful, I do not know if it will streamline into an effective iteration of the curriculum once it is integrated into the program.

Fortunately, certain of the above limitations can be addressed as future steps are taken to establish an effective curriculum. The first thing that should be done is for The Center to hire a licensed clinician who can oversee the task of integrating the expert feedback into the curriculum so that therapeutic integrity is maintained. Of the three parts of the curriculum the expert evaluators reviewed, the first (client files) and third (evaluation methods) will be the least effortful to adjust. For example, the Informed Consent can be modified to include the negative consequences of treatment and information about the Tarasoff ruling, an additional document can be created that describes the phenomenon of domestic violence (e.g., the statistics, facts, myths, etc.), and questions can be added/modified to the Child History Intake Form and other forms as needed.

The Child Behavior Checklist (see Achenbach, 1991) can be added to the client file to provide updates on the child’s behavioral status. Although there is not yet a bilingual version of the curriculum, its development can be considered once the program has proven its effectiveness in an English-speaking community. With regard to the Pre-test/Post-test, aspects of domestic violence and trauma can be added to it as recommended. Additionally, modifications can be made to the Curriculum Evaluation with minimal effort to improve its utility as a program evaluation tool. When a pilot test is scheduled for the first group of participants, I suggest that a third evaluation tool be
developed called a Facilitator Evaluation Form, in order to address session process rather than session content. The form will be completed by 2-3 trained volunteers who will observe each group session, complete a close-ended questionnaire, and take free-form observational notes. Aspects of the curriculum will be evaluated, such as whether it is being implemented in a timely manner, whether the children appear to be engaged in the activities and exercises, whether it is developmentally appropriate for the population, and whether the sessions begin and end on time.

The biggest challenge prior to implementing the program will be to integrate the advice and concerns the experts noted about the group and individual sessions into the second part of the curriculum packet, the curriculum itself. The experts offered excellent suggestions and, although the task will be time-consuming, I do not anticipate it will be insurmountable. The clinician and his/her team can systematically review the comments and adopt whatever recommendations they think are feasible. They might even take advantage of the expertise of TF-CBT’s co-developers, Cohen, Mannarino, and Deblinger. These researchers made themselves available to me during this project and provided critically important suggestions about the SGP curriculum.

Based on the expert feedback, there are both small-scope and large-scope curriculum issues that should be addressed. Small-scope suggestions include the following: Consider devoting more time to domestic violence education; be sure to conduct stress reduction exercises at the start of each session so that clients master the task and are able to do them after the session series is over; expand Session 3 to include psychoeducation on emotions such as fear and sadness, without such an exclusive
emphasis on anger; and, be sure to introduce the notion to both the child and parent early in the series that a trauma narrative will be shared over the course of the sessions. Also, if younger children are unable to do mindfulness exercises, teach them simpler motor/sensory tasks. If possible, introduce children to coping tools in Session 6 before conducting a discussion about trauma triggers or doing any in vivo work.

In the individual sessions, refer to COWS as “Challenges of the Week” rather than “Crises of the Week.” In addition, increase the amount of psychoeducation, self-regulation, and parenting skills provided to the mother. Make sure that she is coached on how to support her child during and after the trauma narrative is shared, and consider expanding the amount of time devoted to the mother throughout the series, as 15 minutes is an inadequate amount of time. During the child’s sessions, start and end with relaxation exercises for emotional regulation, review group session activities prior to each individual session and, for both the child and mother, devote some time to improving communication between them. Finally, be sure to provide professional referrals to the families once the series ends, so they have options for getting additional therapeutic assistance.

Large-scope challenges were also proposed by the expert evaluators. These will require a more thoughtful appraisal of the program as it presently exists. Large-scope suggestions include the following: Reduce the session length from 90 minutes down to 60 minutes per week so that children with limited attention spans can remain present and focused for the duration of the session; in addition, review the material in each session and reduce the number of objectives slated to be addressed. If it appears that all the
objectives deserve attention, consider expanding the program from 8 weeks to 16 weeks so that the facilitator can devote two weekly sessions to each topic. Make sure that different versions of the curriculum are in place and available to accommodate different ages during the group sessions, but still maintain a balance of learning modalities. For example, keep in mind that younger children require more hands-on activities but older children can handle, and benefit from, more lecture and discussion.

Additionally, gradual exposure is a component of TF-CBT but cannot be done in a group setting. In vivo work is also a critical component of TF-CBT for children who require it; therefore, strategies must be developed for providing clients with both of these aspects of the intervention. Finally, it was suggested by one of TF-CBT’s co-developers that group sessions take place after the individual sessions, as the latter should build upon the former. It was mentioned by another co-developer that severely traumatized children never get beyond the skill-building (the PRAC piece) of the intervention, so program facilitators should be mindful of this.

While contemplating options for program improvement, there are two ideas the clinician and his/her team might consider. First, given the transience of the population in an emergency shelter, it might only be feasible to implement the first half of the curriculum; that is, the PRAC piece rather than the entire PRACTICE protocol. Doing this might compromise the Second Generation Project’s original intention of providing both children and mothers with a therapeutic intervention to assist in their recovery from DV trauma, but it will at least provide them with new social skills, information about the cognitive triangle, and various tools for communication, relaxation, and self-healing. If
this approach is taken, clients will have more time to learn about, and reinforce, the psychoeducational aspects of the curriculum. They will have more opportunities to practice relaxation techniques, they will move at a more comfortable pace, and they will not be rushed through any topics on which they want to spend more time. Additionally, they will be less likely to encounter trauma triggers as they move through the program, as the narrative and in vivo work will not be introduced.

The second idea is to not implement the curriculum at the shelter but, instead, segue directly to the grant’s Year 2 goal, which is to introduce the curriculum to the children of all The Center’s clients. This includes children who lived in the shelter at one time but who are now in (hopefully) a more stable environment. It also includes children of clients who never lived in the shelter but who solicited The Center’s services based on the DV they experienced in the past. These mothers might or might not still be taking advantage of The Center’s classes, support groups, or peer counseling sessions; however, this would not be a condition of their inclusion in the Second Generation Project. This population might be more geographically stable and thus able to attend an 8-week curriculum. They are also less likely to be in an acute phase of traumatic stress, compared to the residents of the shelter, and will be able to focus on needs that are beyond those of immediate food, shelter, and employment. Additionally, offering the program to this population might allow facilitators to expand the curriculum from eight weeks to 12 or 16 weeks, which will go far in satisfying many of the experts’ concerns that an 8-week format does not provide enough time to adequately explore the topics and objectives of the program.
Finally, by offering the curriculum to The Center’s wider community of clients, it might be possible to implement Kirkpatrick’s fourth element of a successful evaluation, Results. Kirkpatrick (1994) stated that one of the guidelines for evaluating results is to “allow time for results to be achieved” (p. 65). However, unlike at a company or organization where employees remain long enough to implement that which they have learned in a training session, shelter clients are not necessarily available for follow-up beyond their 8-12 week stay. If the participants are permanent residents of the area, it will be easier for The Center to conduct follow-up sessions in order to assess long-term outcomes of the Second Generation Project’s curriculum; a valuable evaluation tool for an agency hoping to acquire continued funding for this critical program.

The Center for Violence-free Relationships established an ambitious goal when it set out to address the emotional and behavioral challenges of the child victims of domestic violence who live in its emergency shelter. A child living there has been uprooted from her familiar environment, might be in an acute emotional condition, is in an unfamiliar location, does not have access to friends and family, and might not be certain that a safe place exists for her in the world. However, because DV occurs in every neighborhood of every town in the country, and because it can have such a devastating impact on children, it is critical that steps be taken by DV agencies to address the issues with which the children of their clients are struggling.

None of this would be necessary, of course, if partners didn’t hurt partners, but they do. Additionally, it is often a challenge to identify and assist child victims of DV because, for a variety of reasons, their victimized parents resist seeking help. For
example, despite the empirical data collected about DV, it is still steeped in popular myths and stereotypes that are not backed by research. Frequently, these myths minimize the gravity of the experience for the victim, or actually place responsibility or blame on the victim (Staffordshire Women’s Aid, 2009) (see Appendix G). In fact, a woman faces so many barriers to leaving a violent environment that “the average battered woman leaves 7 to 8 times before permanently leaving a relationship” (Alabama Coalition Against Domestic Violence, 2011, para. 15). Therefore, when an agency has the ability to identify and positively influence a child victim of DV, it should work to do so with an adequately funded, thoroughly vetted, evidence-based program that has been shown to bring about positive change in a child’s life. And, bringing about positive change in a child’s life is what the Second Generation Project endeavors to do.
APPENDIX A

Second Generation Project Expert Evaluation Overviews
Expert Evaluation

Of

The Second Generation Project

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“When I grow up, I am going to use my muscles to hit my Mommy just like my Daddy does.”

~~5 year-old boy and son of a client sheltered by The Center for Violence-free Relationships
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Greetings!

Thanks again, so very much, for offering both your time and expertise in order to conduct an expert evaluation of the enclosed curriculum.

I am working in collaboration with The Center for Violence-free Relationships, located in Placerville, California, to develop a ground-breaking project for El Dorado County and it is important that an evaluation of the curriculum's content be completed by a qualified and diverse group of experts. We want to make sure the curriculum is in tip-top shape before it is formally implemented in a group setting.

Additionally, I am completing a 4-year master's program in the Psychology Department at CSU Sacramento. The results of this Expert Evaluation will constitute the core of my Culminating Project (thesis) for my master's degree in Counseling Psychology. I have spent nearly a year doing research, attending meetings, perusing studies, writing drafts, receiving training, and developing a program. Your assistance with this project means a GREAT deal to me; your contribution will not only help propel me toward my academic goals, but will benefit a community of women and children who need guidance and support as they struggle with the aftermath of domestic violence.

Please review the curriculum and respond to the items on the Curriculum Evaluation Form. The more feedback you provide, the more thoroughly I will be able to integrate your comments, compliments, and concerns into the final curriculum.

Because of the goals and deadlines that have been set for this project, I would like to ask that you give yourself a 6-10 day turnaround for the completion of your expert evaluation. You will receive an electronic copy of the evaluation form; simply fill it out and send it to the following email address: xxxx@aol.com

This binder contains a hard copy of all the overviews, assessment tools, curriculum materials, and program evaluation forms for you to review. Feel free to keep the binder when you are done.

Thanks again for your time and valuable insight. I am forever grateful to you for offering your expertise and reflection.

Alison Ehlers,  
Master’s candidate, Counseling Psychology  
California State University, Sacramento
OVERVIEW OF THE SECOND GENERATION PROJECT (SGP)

The Second Generation Project (SGP) is a 3-year effort by The Center for Violence-free Relationships ("The Center") in Placerville, CA. It was made possible by a grant provided by the El Dorado Community Foundation. The goal of SGP is to develop and implement a comprehensive counseling curriculum specific to youth who have experienced family violence. The project, facilitated by a licensed therapist, will become part of the core wraparound services for families residing in The Center’s shelter. Over the 3-year period, the project will expand beyond families residing in the shelter to all of The Center’s clients and their children, as well as to youth and families in the larger community whose lives have been impacted by domestic violence.

According to the grant, the ultimate goal of SGP is to be a part of the process of “healing of the entire family through intervention/prevention education counseling to stop the inter-generational transmission of violence.”

The Center was founded in 1980 and serves western El Dorado County. It is dedicated to building healthy relationships, families, and communities free from sexual assault and domestic violence through education, advocacy, and services, and has served over 22,000 victims to date. The Center provides the following services:

- 24-hour crisis line; individual counseling, drop-in counseling, and group support for victims; emergency food, clothing, and transportation; legal assistance and accompaniment; a safe house; hospital and court accompaniment and advocacy; information and referrals; group counseling for those who have battered their partners; community education; school prevention programs; and training for volunteers.

The goals of the Second Generation Project include the following:

- **Break the Silence** – Encourage children to talk about their experience.
- **Emotional Coping and Development of Positive Behavior Patterns** – Teach children about boundaries and the cognitive triangle (relationship/distinction between thoughts, feelings, and behaviors). Reassure them that family violence is not their fault.
- **Parent Training** – Give non-abusing parent coping skills to understand and respond to child’s sadness and sense of loss. Develop techniques to manage their child’s negative behaviors.
- **Create a Healing Environment** – Help the family create a safe, stable, and nurturing environment for the child. Encourage consistent routines and reinforce the parent-child bond.
OVERVIEW OF TF-CBT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment approach that has been shown to help children overcome trauma-related difficulties by reducing negative emotional and behavioral responses following traumatic events. It was developed by E. Deblinger, J.A. Cohen, and A.P. Mannarino in 1996 to address child sexual abuse, but subsequent research has demonstrated that it is an efficacious treatment for a variety of traumatic events, including community violence, accidents, natural disasters, terrorism, loss of a loved one, and domestic violence.

TF-CBT attempts to reduce trauma symptoms that include:

- Maladaptive or unhelpful beliefs
- Acting-out behaviors
- Mental health disorders, such as depression
- PTSD symptomology, including
  - Intrusive thoughts
  - Avoidance of trauma reminders
  - Emotional numbing
  - Irritability
  - Trouble sleeping or concentrating

It also attempts to help the child’s non-offending caretaker (in this case, the mother) cope with her own emotional distress, and to provide her with skills to more effectively support her child.

Components of the TF-CBT protocol are summarized by the acronym “PRACTICE”:

- **P** – Psychoeducation and parenting skills
- **R** – Relaxation techniques
- **A** – Affective expression and regulation
- **C** – Cognitive coping
- **T** – Trauma narrative
- **I** – In vivo exposure
- **C** – Conjoint parent/child sessions
- **E** – Enhancing personal safety

But – Does it work? Over a dozen outcome studies have revealed that children show significant reductions in intrusive thoughts, avoidance behaviors, depression, anxiety, behavior problems, shame/guilt, and disassociation after undergoing TF-CBT. Additionally, they demonstrate improved interpersonal trust and social competence.

More information can be found at:

- National Crime Victims Research & Treatment Center (NCVC): http://colleges.musc.edu/ncvc/
OVERVIEW OF THE CURRICULUM

The 3-year grant provided to The Center to implement the Second Generation Project (SGP) required that evidence-based practices be researched in order to select a protocol that would best address the primary goals of SGP.

We selected Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) because of its efficacy, the amount of facilitator training required, the cost of development, the time required for implementation, and its relative portability. In addition, it was appropriate for children aged 3-17, addressed PTSD symptomology resulting from trauma related to domestic violence, and was supported by an extensive body of research.

There are, however, aspects of SGP that make implementation of TF-CBT a challenge, as little research has been conducted under the following circumstances:

- It is to be implemented in a group format.
- There will potentially be a wide range of ages in the group.
- It will be a time-limited, rather than an open-ended, intervention.
- The clientele will be transient in nature, as The Center is a crisis-focused agency.

This is what is planned:

- A licensed clinician will complete a thorough intake assessment of mother and child(ren).
- A customized Goals & Needs list will be completed for each participant.
- Implementation of TF-CBT will be in the form of an 8-week group curriculum.
- Children will attend one 90-minute group session and one 45-minute individual session each week.
- Mothers will attend one 15-minute individual session each week.
- Each week, an aspect of TF-CBT’s PRACTICE acronym will be addressed (see Overview of TF-CBT) in the group sessions and homework will be assigned. (For the sake of brevity, homework handouts have been condensed into a table in Section 3.)
- Individual child sessions will consist of a check-in, review of homework/skills learned in the previous group session, and review of the Goals & Needs list.
- Individual parent sessions will consist of a check-in, skill-building for parent/child effectiveness, and helpful handouts.
- Creating a Personal Story (Trauma Narrative) is a critical aspect of TF-CBT but should not be done in a group format. Instead, it will be created in the child’s individual sessions 4, 5, and 6. In session 7, the child will share the narrative with his/her mother.
- Because the curriculum is time-limited (8 weeks), it is NOT expected that the child’s therapeutic experience will be intense and exhaustive. Instead, it will consist of skill-building and the sharing of a story.
OVERVIEW OF THE PROGRAM EVALUATION

There are two tools that clients will use to evaluate the overall program (see Section 4).

The first tool is a pre-test/post-test. The pre-test will be administered to the child during the initial assessment phase of the program and will establish a baseline of knowledge and skills. The post-test will be administered during the final individual session and will evaluate the skill-building mastery and knowledge the child has acquired over the course of the program.

The second tool is a program evaluation form, which will evaluate the program’s overall effectiveness. The child will fill this out during the final individual session and will provide us with subjective feedback about various aspects of the program, such as activities, lectures, discussions, and individual sessions, which the child experienced.

Please note:

Mothers will also complete a program evaluation form during the final individual session.

In addition, a parent file will be established that is somewhat similar to the child file (see Section 2); the only difference is that the mother will complete a Shelter Resident Intake Form that focuses on her own history and present status. For the sake of brevity, the parent file and parent program evaluation have not been included in this packet.
APPENDIX B

Expert Evaluation Form
EXPERT EVALUATION FORM

Please complete the top portion. Then, respond to the questions and share your thoughts, both positive and negative, about the curriculum. Your feedback is very important to us; critical, in fact. We think the curriculum is in good shape, but we are very close to it and lack both the objectivity and expert perspective you will be able to provide.

Date:

Name:

Job Title:

Areas of Expertise:

Years of Clinical Experience:

Past Experience (Please include any work in Education, Curriculum Development, Group Therapy, Individual Therapy, Research, Child Therapy, Social Service Agency work, DV/SA work):

Have you ever used a version of TF-CBT? Please describe:

Have you ever developed curricula as a therapeutic intervention? Please describe:

Section 1 –

Overviews
Please read the Overviews to familiarize yourself with TF-CBT, SGP, and the curriculum.

Section 2 –

Child Client File
Please look through the contents of the Child Client File. It contains:
1. Informed Consent Agreement
2. Child History Intake Form
3. Symptom Checklist
4. UCLA PTSD Index for DSM IV, Child Version
5. Exchange of Information Form
6. Blank Progress Notes
What are your impressions of the contents of the Child Client File?

Does it contain the necessary tools for an adequate assessment?

Section 3 –

Curriculum – Group Sessions – Weekly Format

Please review Sessions 1-8. (Note that the first 2-3 rows and last 3 rows are essentially the same each week.)

Sessions 1-8:
1. Do the Session Topics satisfy the Session Objectives in each session?

2. Do the topics address the protocols contained in TF-CBT’s “PRACTICE” acronym?

3. Is there an adequate balance of learning modalities to satisfy the various learning styles of the group participants? (e.g., activity, discussion, storytelling, lecture, etc.)

The goals of the curriculum are as follows:
1. Awareness/Education
2. Skill-building
3. Connection with mother
4. Reduction of trauma symptomology

Curriculum Goals

1. Awareness/Education
   • Session 1: Does its objectives meet this goal? Why/Why not?
   • Session 8: Does its objectives meet this goal? Why/Why not?

2. Skill-building
   • Session 2: Does its objectives meet this goal? Why/Why not?
   • Session 3: Does its objectives meet this goal? Why/Why not?
• Session 4: Does its objectives meet this goal? Why/Why not?

3. **Connection with mother**

• Session 7: Does its objectives meet this goal? Why/Why not?

4. **Reduction of trauma symptomology**

• Session 5: Does its objectives meet this goal? Why/Why not?

• Session 6: Does its objectives meet this goal? Why/Why not?

**Curriculum – Individual Sessions – Weekly Format**

Please review the contents of the Individual Sessions.

1. What are your impressions?

2. Do they complement the weekly group sessions?

3. What would you like to see added to the individual sessions?

**Section 4 – Evaluation Methods**

Please review the contents of the Evaluations.

1. Does the Pre-test/Post-test adequately evaluate the skills learned in the group sessions?

2. Does the Curriculum Evaluation Form solicit the feedback we need to improve the curriculum for future sessions?

Final Thoughts:
Please add any final thoughts you have about the curriculum, both positive and negative. Your feedback is very important to us!

Thank you SO much for your time and expertise!! You are wonderful!
APPENDIX C

Child Client File
INFORMED CONSENT AGREEMENT

The relationship between you and your counselor is very important in the therapy process. The goal is to build trust so counseling can help you to help yourself as you create the changes necessary for a better life. The counselor is committed to honoring your process and working collaboratively with you to create these changes. It takes courage to talk and trust; the effort is worth it.

There are many possible benefits of counseling for those who undertake it. It often leads to a reduction of feelings of distress, improved relationships, and the resolution of specific problems.

As part of the counseling process, the therapist is bound by ethical responsibilities to keep confidential the information shared during the sessions. There are important exceptions to the confidentiality of the counseling relationship. The counselor is required or permitted by law and/or professional ethics to reveal certain information under the following circumstances:

- If you provide information that leads the counselor to believe that you may physically harm yourself or another individual.
- If you reveal to the counselor incidents of child abuse or neglect, or the abuse/neglect of elderly or dependent persons.
- If a court of law orders the release of specific information.

The counseling that you receive will be provided by one or more of the following: Licensed Clinicians, Graduate Counseling Trainees, Graduate Counseling Interns, or trained Peer Counselors.

If the counseling services are to be provided to individuals under the age of eighteen (18) years, I have entered the name and age of each child in the space below. By signing this agreement, I confirm that I am the parent or legal guardian of the child(ren). The child(ren) who will be seen include:

Name________________________ Age____  Name________________________ Age____

Name________________________ Age____  Name________________________ Age____

I have read the above information and by signing below I am stating that I understand the contents of this agreement and agree to participate in counseling.

_____________________________  ________________
Client signature               Date

I have reviewed this agreement with the client listed above.

_____________________________  ________________
Therapist                   Date

[Rev: 1/11]
CHILD HISTORY INTAKE FORM

DATE: _________________________

CHILD’S NAME: ____________________ BIRTHDATE: ____________________ AGE: ______

Parent (Guardian): ______________________________________________________________________
Address: ______________________________________________________________________________
Home Phone: ___________________________________ Cell Phone: _____________________________

Others living in the home:
NAME                 AGE/BIRTHDATE      RELATIONSHIP  OCCUPATION
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Please explain: ________________________________________________________________________
______________________________________________________________________________________

EDUCATION:
Did your child attend preschool? ________ Head Start? ________ Kindergarten? ________
Current grade: ___________ School: ____________________________
Teacher: ____________________________

Has the child had difficulty going to school? _______________________________________________
Has the child been retained or been in special education classes? _____________________________
What does the child do well in school? ______________________________________________________
What does the child do poorly in school? ____________________________________________________
Does the child get along with other students? _______________________________________________
Does the child get along with teachers and school staff? ______________________________________

PREGNANCY HISTORY FOR THE CHILD:
Did the child’s mother have any serious illnesses during the pregnancy? _______________________
  Explain: _____________________________________________________________________________

Type of delivery: ____________________________ Other issues: _______________________________
Did the child’s mother use drugs or drink alcohol during the pregnancy? _____________________
  Describe: __________________________________________________________________________________
**DEVELOPMENTAL:**
At what age did your child do the following?
Sat up: ___ Crawled: ____ Walked: ______ Talked: _________ Stopped wetting diapers: ______
Was potty-trained: __________________ Ran/throw a ball: ____________________________
Please describe your child’s general development: Slow _______ Normal: ______ Fast: _________

**MEDICAL:**
Child’s height: ______________ Child’s weight: ________________
Did your child visit a physician due to physical abuse by the offender? _____________________________
List any serious illnesses, injuries, and operations of your child, and his/her age when they occurred:
__________________________________________________________________________ Age: ____________
__________________________________________________________________________ Age: ____________
__________________________________________________________________________ Age: ____________
List all the medications your child is taking: __________________________________________________
____________________________________________________________________________________
Child’s physician: _____________________________________________________________________
Does your child have any visual problems? ________________________________________________
Are your child’s immunizations up-to-date? _________________________________________________
Has your child been diagnosed with ADD or ADHD? _________________________________________
Has your child had mental health treatment? ______________________________________________
Name of treating therapist: ______________________________________________________________
Does your child have any learning disabilities? Please list: _________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**LEGAL**
Has your child ever been in trouble with the law? Please explain: ______________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**DOMESTIC VIOLENCE HISTORY**
Did your child witness episodes of violence in the home? ________________________________
• How often?
Was s/he a direct victim of the domestic violence? ________________________________
• How often?
At what age did s/he first experience domestic violence? ________________________________
When was the last episode of domestic violence in your home? ________________________________
Was your child exposed to drugs, alcohol, or weapons in the home? ________________________________
Does your child watch violent TV shows? Play violent video games? ________________________________
Was there, or do you suspect that your child experienced, sexual abuse? ________________________________
Please explain: ________________________________
____________________________________________________________________________________
____________________________________________________________________________________
How do you think domestic violence affects your child? Describe his/her thoughts and behaviors: ________________________________
____________________________________________________________________________________
____________________________________________________________________________________
What does your child do to protect him/herself from domestic violence? ________________________________
What do you do to help protect your child? ________________________________
____________________________________________________________________________________
Does your child have friends/family that help when domestic violence occurs? Please Explain: __________

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Does your child’s school know about the domestic violence? □ Yes. □ No.
   • Has school personnel helped your child? Explain: __________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
   •

If you attend faith services, have you or your child received help from that community for the domestic violence? □ Yes. □ No. Explain: _________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

What kind of protection does your child require when you are not at home? _____________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Does your child have a safety plan in place if he/she feels threatened? Please explain: __________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

BEHAVIORAL PROBLEMS – PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

<table>
<thead>
<tr>
<th>Lying</th>
<th>Thumb-sucking</th>
<th>Daydreaming</th>
<th>Learning problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stealing</td>
<td>Nail-biting</td>
<td>Fears or phobias</td>
<td>Social problems</td>
</tr>
<tr>
<td>Running</td>
<td>Bed-wetting</td>
<td>Nightmares</td>
<td>Crying spells</td>
</tr>
<tr>
<td>away</td>
<td>Fire-setting</td>
<td>Night terrors</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Speech</td>
<td>Destroying property</td>
<td>Depression</td>
<td>Poor appetite</td>
</tr>
<tr>
<td>problems</td>
<td>Temper outbursts</td>
<td>Suicidal thoughts</td>
<td>Agitation</td>
</tr>
<tr>
<td></td>
<td>Shyness</td>
<td>Sleep-walking</td>
<td></td>
</tr>
</tbody>
</table>

CHARACTERISTICS – PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

<table>
<thead>
<tr>
<th>Aggressive</th>
<th>Anxious</th>
<th>Argumentative</th>
<th>Awkward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bossy</td>
<td>Competitive</td>
<td>Depressed</td>
<td>Distractible</td>
</tr>
<tr>
<td>Fearful</td>
<td>Quarrelsome</td>
<td>Reckless</td>
<td>Shy</td>
</tr>
<tr>
<td>Sly</td>
<td>Stubborn</td>
<td>Submissive</td>
<td>Timid</td>
</tr>
<tr>
<td>Tense</td>
<td>Touchy</td>
<td>Whiny</td>
<td>Withdrawn</td>
</tr>
</tbody>
</table>

STRENGTHS – PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

<table>
<thead>
<tr>
<th>Helpful</th>
<th>Adventurous</th>
<th>Upbeat</th>
<th>Cooperative</th>
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</thead>
<tbody>
<tr>
<td>Kind</td>
<td>Affectionate</td>
<td>Hopeful</td>
<td>Forgiving</td>
</tr>
<tr>
<td>Funny</td>
<td>Curious</td>
<td>Carefree</td>
<td>Sociable</td>
</tr>
<tr>
<td>Caring</td>
<td>Friendly</td>
<td>Calm</td>
<td>Energetic</td>
</tr>
<tr>
<td>Good in school</td>
<td>Loving</td>
<td>Good in sports</td>
<td>Trusting</td>
</tr>
<tr>
<td>Artistic</td>
<td></td>
<td>Honest</td>
<td>Hardworking</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Sensitive</td>
</tr>
</tbody>
</table>
Please list any other strengths that your child exhibits: ____________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**PETS**
Do you have any pets/animals? □ Yes. □ No. If yes, please describe: ____________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Has your partner ever threatened your pet? □ Yes. □ No. Explain: __________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Has your pet ever been kicked, tossed, hit, shoved, burned, neglected, or deprived of food? Please explain:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Has your child ever taken his/her anger out on an animal? □ Yes. □ No. Explain: ______________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Do you sometimes fear for your pet’s safety? □ Yes. □ No. Explain: ________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Is your pet presently in a safe place? □ Yes. □ No. Explain: _________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Have you heard of our Safe Pet Program? □ Yes. □ No.

Please add any additional information that you feel is appropriate or significant:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Thank you for your time.

[Rev: 1/11-aae]
SYMPTOM CHECKLIST

Please put a check next to any symptoms that your child is experiencing:

**Physical Challenges**
[ ] Poor appetite  
[ ] Cannot sleep/Prefers to sleep with mother  
[ ] Headaches  
[ ] Stomach pains  
[ ] Nausea  
[ ] Hair-plucking  
[ ] Self injury  
[ ] Rocking  
[ ] Accident-prone  
[ ] Eating disorders

**School Challenges**
[ ] Grades are declining  
[ ] Suffers poor concentration  
[ ] Has a poor memory  
[ ] Is withdrawn  
[ ] Behaves aggressively  
[ ] Has difficulty solving problems  
[ ] Gets bullied by other kids  
[ ] Acts out in class

**Interpersonal Challenges**
[ ] Excessive worry  
[ ] Poor social skills  
[ ] Fearful of others  
[ ] Misses the offending parent  
[ ] Doesn’t trust adults  
[ ] Tends to be a “problem child”
### Section 1: Events of Your Life

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
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<th>8.</th>
<th>9.</th>
<th>10.</th>
<th>11.</th>
<th>12.</th>
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<tbody>
<tr>
<td>Being involved in a violent death or serious injury of a loved one.</td>
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<td>When you did not want to</td>
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<td>Having an adult or someone who does not use their sexual organs</td>
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<td>Seeing a dead body in your town (do not include animals)</td>
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<td>Seeing someone in your town being beaten, hit, or killed</td>
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<td>Being present when a violent death or serious injury happened to you</td>
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<td>Being present when a violent death or serious injury happened to someone you know</td>
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<td>Being in a place where a violent death or serious injury happened to you</td>
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<td>Being in a place where a violent death or serious injury happened to someone you know</td>
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<tr>
<td>Being in a place where a violent death or serious injury happened to someone you love</td>
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<td>Being in a place where a violent death or serious injury happened to someone you hate</td>
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</table>

### Section 2: Events of Your Life

- Check "Yes" if this thing happened to you.
- Check "No" if it did not happen.
- People have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen.

**Additional Notes:**
- If you checked "Yes," please provide more details.
- If you checked "No," please indicate why.

---

**Interviewer's Notes:**
- Date: [Month, Day, Year]
- Time: [Time]
- Location: [Location]
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(1) Did someone die?
Yes [ ] No [ ]

(2) Was someone else hurt badly?
Yes [ ] No [ ]

(3) Were you scared that someone else would be hurt badly?
Yes [ ] No [ ]

(4) Were you scared that you would die?
Yes [ ] No [ ]

(5) Were you scared that you would die?
Yes [ ] No [ ]

The event that the bad thing happened that you just wrote about in question 1:

For the next questions, please check [YES] or [NO] to answer how you felt during or after the event that the bad thing happened that you just wrote about in question 1:

Please write what happened:

(6) What did you feel like happened?
Yes [ ] No [ ]

(7) How long ago did this bad thing (your answer to [6]) happen to you?

(8) How often does this bad thing happen?

(9) If you answered "YES" to any ONE of the above, has ANYTHING ELSE ever happened to you that was REALLY SCARY, DANGEROUS, OR VIOLENT?
Yes [ ] No [ ]
### The Past Month

<table>
<thead>
<tr>
<th>Day</th>
<th>How Much of the Time During the Past Month</th>
<th>None</th>
<th>Little</th>
<th>Some</th>
<th>Much</th>
<th>Most</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

#### Please Be Sure To Answer All Questions

To help you decide how often the problem has happened in the past month, use the table on Page 3 or 4. Think about the problem that happened to you in the past month. Write the number (0, 1, 2 or 3) that tells how often the problem has happened to you in the past month. Use the table on Page 3 or 4. Enter each problem on the list carefully. Circle one of the numbers above the bars that happen to you.

Here is a list of problems people sometimes have after very bad things happen:

- It was going on in a movie that really scared or real life?
- Did you feel like when was happening did not seem real in some ways, like a movie?
- Did you feel very confused?
- Did you feel very upset? You needed someone to help?
- Did you feel very scared, like this was one of your most scary experiences ever? Yes No

---

**ICF-PASID INDEX FOR DSM-5**

Page 2 of 3
<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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**How Much of the Time During the Past Month**

**Past Month**

- 110
- 190
- 180
- 120
- 100
- 90
- 80
- 30
- 10

*Note: The table and text are not legible due to the image quality.*
**Frequency Rating Sheet**

<table>
<thead>
<tr>
<th>NEVER</th>
<th>TWO TIMES 1-2 TIMES</th>
<th>ALMOST 2-3 TIMES</th>
<th>EACH WEEK</th>
<th>A WEEK</th>
<th>EVERY DAY</th>
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<td>EACH WEEK</td>
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</table>

**Does the problem happen during the last month, that is since how often or how much of the time?**

- None
- Little
- Some
- Much
- Most

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<th>0</th>
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<th>4</th>
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</thead>
</table>

Unclassified Index for DSM 11

Page 5 of 5
AUTHORIZATION FOR
EXCHANGE / RELEASE OF INFORMATION

AUTHORIZATION is hereby given for verbal / written information regarding

__________________________________________________________________________
to be exchanged / released between The Center for Violence-free Relationships and

__________________________________________________________________________.

Only information specifically indicated by the client may be released. This release
is not an authorization for The Center’s representatives to provide testimony in
court. This authorization is valid until ____________ (1 year).

__________________________________________________________________________
Client Signature                      Date

__________________________________________________________________________
Witness Signature                     Date
The Center for Violence-Free Relationships
Second Generation Project

~Progress Notes~

Client: ______________________________________

Date: ________________

Feedback:____________________________________________________________________

_____________________________________________________________________________

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Session:______________________________________________________________________

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_____________________________________________________________________________

Intervention:__________________________________________

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Client Assignment: ______________________________________

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Therapist Follow-Up:_____________________________________

_____________________________________________________________________________

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[Rev: 2/2011]
The Center for Violence-Free Relationships
Second Generation Project

~Client Log~

Client: ____________________________

<table>
<thead>
<tr>
<th>Session</th>
<th>Date</th>
<th>Therapist (Init.)</th>
<th>Clients</th>
<th>Procedure Codes</th>
<th>Session Length</th>
<th>Type (Indiv/Grp/Conj)</th>
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[Rev: 2/2011]
| *CLIENT CALL: | | | | | DV | SA |
|______________|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|
| Crisis | | | | | | |

| * Information | | | | | | |
| * IN PERSON COUNS. | | | | | | |
| * Drop-In | | | | | | |
| * GROUP | | | | | | |

| Advocacy and Accomp. | | | | | | |
|______________________|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|
| * Sec. Svc. | | | | | | |
| * Legal-Civil | | | | | | |
| * Crim. Court | | | | | | |
| * Crim. Other | | | | | | |
| * Hospital | | | | | | |

**FOLLOW-UP**

| * MOTEL | | | | | | |
|________|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|

| ASSIST. W/TRO, EPO, CPO | | | | | | |
|_______________________|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|
| Temp. Req. | Grant | Final Req | Grant | | | |

| *FAMILY LAW ASSIST. | | | | | | |
| (legal staff only) | | | | | | |

| *CRIMINAL JUSTICE | | | | | | |
| ASSIST. (legal staff only) | | | | | | |

| ASSIST AT OFFICE (In Person) | | | | | | |
|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|
| * EMERG CALL: | | | | | | |
| From Medical | | | | | | |
| *From LE | | | | | | |

| *REFERRALS (All) | | | | | | |
|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|__________________________|

| REFERRALS: | | | | | | |
| Coun.-Adult | | | | | | |
| *FOOD/CLOTH | | | | | | |
| REF-Food/Cloth | | | | | | |
| REF - Group DV | | | | | | |

| SHELTER: REQUESTED | | | | | | |
| Turned Away: | | | | | | |
| Full | Not appro | Other | REF - Shelter | | | |

| *TRANSPORTATION | | | | | | |
| *EMERG.TRANSP. | | | | | | |
| *ASST W/SAFETY PLAN | | | | | | |

| REF-TRO/Custody | | | | | | |
| PREPARE TRO | | | | | | |
| HOUSEHLD ESTAB. | | | | | | |

| ASST W/CUST. (No RO Asst) | | | | | | |
| *INFO Cust/Support/Dissol | | | | | | |
| Civil of Cl FJ | | | | | | |

---

Emergency Housing/Motel: Salvation Army | The Center | All Financial Assistance
Utility Assistance | Rental Assistance | Unerved & Underserved
Pets

Mark each time you provide service in this category
Services by atty are circled

FY 10/11
APPENDIX D

Parent Client File
INFORMED CONSENT AGREEMENT

The relationship between you and your counselor is very important in the therapy process. The goal is to build trust so counseling can help you to help yourself as you create the changes necessary for a better life. The counselor is committed to honoring your process and working collaboratively with you to create these changes. It takes courage to talk and trust; the effort is worth it.

There are many possible benefits of counseling for those who undertake it. It often leads to a reduction of feelings of distress, improved relationships, and the resolution of specific problems.

As part of the counseling process, the therapist is bound by ethical responsibilities to keep confidential the information shared during the sessions. There are important exceptions to the confidentiality of the counseling relationship. The counselor is required or permitted by law and/or professional ethics to reveal certain information under the following circumstances:

- If you provide information that leads the counselor to believe that you may physically harm yourself or another individual.
- If you reveal to the counselor incidents of child abuse or neglect, or the abuse/neglect of elderly or dependent persons.
- If a court of law orders the release of specific information.

The counseling that you receive will be provided by one or more of the following: Licensed Clinicians, Graduate Counseling Trainees, Graduate Counseling Interns, or trained Peer Counselors.

If the counseling services are to be provided to individuals under the age of eighteen (18) years, I have entered the name and age of each child in the space below. By signing this agreement, I confirm that I am the parent or legal guardian of the child(ren). The child(ren) who will be seen include:

Name_________________________ Age______ Name_________________________ Age______
Name_________________________ Age______ Name_________________________ Age______

I have read the above information and by signing below I am stating that I understand the contents of this agreement and agree to participate in counseling.

___________________________ Date __________
Client signature

I have reviewed this agreement with the client listed above.

___________________________ Date __________
Therapist

[Rev: 1/11]
SHELTER RESIDENT INTAKE

Date ___________________________ Intake counselor: _______________________

Resident’s name: __________________________________

Most recent address:_________________________________________________________________________
______________________________________________________________________________________

Date of Birth: __________ SS#: ________________ Phone: ________________ 1st day at shelter: _______

Vehicle: ________________________________________________
Make ___________________ Model ___________________ Year ________________ License plate ________________

Relationship to abuser immediately prior to shelter arrival (choose one):
Married: ___  Divorced: ___  Separated: ___  Unmarried/Living together: ___  Not living together: _____

Other (specify): _______________________________________________________________________

How long have you known the abuser? ______________________________________________________

How long have you been in a relationship with the abuser? ______________________________________

How long have you lived together (if applicable)? _____________________________________________

What happened that brought you to the shelter? _______________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Do you presently have any injuries (bruises, marks, wounds)?  Yes _____  No _____ I f yes, explain:
______________________________________________________________________________________

Did you receive medical care? Yes _____  No _____ Name of hospital/doctor and approximate dates:
______________________________________________________________________________________

Have you incurred injuries in the past? Yes _____  No _____ Name of hospital/doctor and approximate
dates: ________________________________________________________________________________

Have you ever pressed charges against your abuser? Yes _____  No _____ Please explain: ______________
______________________________________________________________________________________

When did your abuser first treat you abusively? _______________________________________________

What was the pattern of abuse in the relationship (frequency, type of abuse, severity, “honeymoon” phase)?
______________________________________________________________________________________

Does your abuser possess any weapons? Yes _____  No _____  Explain: ____________________________

Has your abuser threatened to use weapons? Yes _____  No _____  Explain: _________________________

What kind of security risk is your abuser? Will he/she try to locate you? Has he/she done so or threatened
to do so before? Explain: __________________________________________________________________________

Do you intend to leave the relationship? Yes ___  No ___  Have you done so before? Yes _____  No _____
How many times? ___________ What happened? ______________________________ _______________

Is this time any different? Yes _____ No _____ If so, why? ______________________________________

Have you sought help before? Yes _____ No _____ If yes, how? ______________________________

Have you ever stayed at a shelter before? Yes _____ No _____ When and where? ____________________

Has your partner been sexually abusive (physically forces or threatens; degrades or hurts you during sex; commits spousal rape)? Yes _____ No _____ Explain: __________________________________________

Does your abuser destroy property? Yes _____ No _____ Explain: ______________________________

**Abuser Information**

Name: ____________________________ Date of Birth: __________________ Phone: _______________

Address: __________________________________________________________________________

Occupation: _______________________________ Employer: ____________________________________

Business phone: __________________________ Income per year: $____________________

Vehicle: ________________ _________________ ________________ _____________
Make   Model   Year   License plate

Description of your abuser:
Height: ________ Weight: ________ Hair color: ________ Eye color: ________ Hair length: ______

Mustache: Yes _____ No _____ Beard: Yes _____ No _____ Earrings: Yes _____ No _____
Tattoos: Yes _____ No _____ Describe: _____________________________________________________

Other distinguishing characteristics: _________________________________________________________

Manner of dress: ________________________________________________________________________

Any other important details: ________________________________________________________________

Is your abuser on probation or parole? Yes _____ No _____ Parole officer: _______________________

Is there a restraining order against your abuser? Yes _____ No _____ Explain: ______ _________________

Does your abuser have a past history of violence (previous partners, childhood assaults)? Yes ___ No _ ___

What kind of support system does your abuser have (family, friends, employer)? _____________________

Has your abuser ever received counseling? Yes _____ No _____ Explain: __________________________

Does your partner abuse alcohol or other substances? Yes _____ No _____ How often? _______________

Specify substances: ________________________________________________________________________

Has your partner received treatment for alcohol/substance abuse? Yes _____ No _____ Explain: ________

What is your history of alcohol/substance use or abuse? _________________________________________

___________________________________________

Were you abused in any previous adult relationships? Yes _____ No _____ Explain: ________________

Were you emotionally/verbally abused as a child? Yes _____ No _____ Explain: ________________

______________________________________________________________________________________
Were you physically abused as a child? Yes _____ No _____ Explain when and by whom: ______________________

Were you raised in a family that had a history of violence? Yes _____ No _____ Explain: ________________

Were your parents abused as children? Yes _____ No _____ Explain: ________________________________

Do you have children? Yes _____ No _____ If so, list first/last names and ages:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Name</th>
<th>Age</th>
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<tbody>
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</table>

Do any of the children have special needs or concerns (health, diet, medication)? Yes _____ No _____

Explain: ____________________________________________________________________________________

Have other agencies worked with your children? Yes _____ No _____ Explain: ______________________

What social services have you used or are presently using? TANF ____ CPS ____
SNAP (Food stamps) ____ WIC ____ Legal Aid ____ SSI ____ DSI ____ CalWORKs: ____ Other: ________________

What was your source of income when you first entered the shelter? ________________________________

Monthly amount: $________________________

What are your immediate needs? ______________________________________________________________

Do you have a plan? Yes _____ No _____ Explain: ______________________________________________

In case of an emergency, who should we contact?

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Relationship</th>
</tr>
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<tbody>
<tr>
<td>___________</td>
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</tbody>
</table>

Name of counselor at The Center Contact number

_________________________________________________

Resident’s signature (Optional)

[Rev: 01/11-aae]
ARE YOU BEING ABUSED?

**Verbal Abuse**
Does your partner consistently say or do things that shame, embarrass, ridicule or insult you? Has he/she said to you, in front of others, or about you to others:
- You’re stupid, filthy, lazy, nasty, silly, etc.
- You’re fat, ugly, a whore, slut, bitch, cunt, etc.
- You can’t do anything right
- You’ll never get a job or make enough to live on
- You’re an unfit mother/father/partner
- You don’t deserve anything
- Who would want you?
- It’s your fault.

**Emotional Abuse**
Does he/she:
- Isolate you from friends and/or family?
- Withhold affection?
- Threaten to hurt you or your children?
- Get in your face & yell or scream?
- Forbids you to work, handle your own money, or make decisions?
- Withdraw sexually or emotionally?
- Force you to sign over property or give him/her your personal possessions?
- Accuse you of having affairs?
- Make you be there when he/she calls?
- Force you to carry a beeper?
- Anticipate his/her every need?
- Undermine your sense of power or confidence?
- Manipulate you with lies, contradictions, or promises?
- Change the rules?
- Laughs at you when you’re trying to be serious?
- Refuse to surrender control of money?
- Threaten to turn you in for outstanding citations, non-compliance with immigration or welfare?
- Plays with or cleans weapons during a conversation?
- Blames you for the children’s misbehavior?
- Keeps you from calling for help or other support?
- Says everything belongs to him/her?
- Prevents you from sleeping?
- Abandons you when you need support the most?
- Threatens your family or future partners?
- Picks on child(ren) from your former relationship, more demanding or strict, etc. than with mutual children?
- Makes sudden loud noises or movements to scare you?
- Refuses to communicate/total silence with you?

**Sexual Abuse**
Does your partner:
- Force you to have sex when you don’t want to?
- Force you to perform sexual acts you don’t like (anal sex, foreign objects, oral sex, sex with animals, etc)?
- Criticize your sexual performance?
- Deny you sex?
- Force you to have sex with or to watch others or view pornography?
- Threaten to hurt you if you don’t desire sex?
- Sex is a said or unsaid duty you must perform?

**Destructive Acts**
Does your partner:
- Break furniture, flood rooms, ransack or dump garbage in your home?
- Slash tires, break windows, steal, tamper with parts or put foreign substances in the gas tank of your car?
- Kill, threaten to kill, or neglect pets to punish or frighten you?
- Destroy your clothing, jewelry, family photos or other important personal items that he/she knows are important to you?
- Rip the phone off the wall or disable the phone?
- Target practice inside the house?
- Destroy property?

**Physical Abuse**
Does your partner:
- Hit, slap, punch, shove, bite, cut, strangle, kick, burn, pinch, spit on you or poke you in the chest repeatedly?
- Throw objects at or restrain you?
- Hurt you with an object or deadly weapon (a gun, knife, baseball bat, brick, chain, hammer, scissors, rope, belt buckle, extension cord, branch, bottle, acid, bleach or scalding water, hot food or drink)?
- Too rough with children?
- Neglect you when you are sick or pregnant?
- Endanger you or your children through reckless driving?
- Attempt to drown you?
- Pull your hair/drag you by your hair?

FY08/09
PARTICIPATION IN THE SECOND GENERATION PROJECT

The Second Generation Project (SGP) is a curriculum developed by The Center for Violence-Free Relationships that teaches children various life skills. It helps them cope better with the stressors of daily living and with the trauma they might have experienced while living in a violent environment. The curriculum includes relaxation techniques, communication skills, information about thoughts and feelings, creative play, role-modeling, art projects, trust-building, and enhanced safety development.

The curriculum is comprised of several initial interviews, eight group sessions, and eight individual sessions. Parts of the curriculum will be taught to the kids in children’s group sessions, and other parts of the curriculum will be taught to both the kids and parents in parent-child sessions. The curriculum will be administered by trained peer counselors and licensed clinicians.

During your residence at The Center’s safe house, you agree to have your child(ren) participate in both the group and individual sessions of the SGP curriculum for the duration of your stay. Additionally, you, as his/her parent, agree to participate in the group and individual parent sessions of the SGP curriculum for the duration of your stay. Please note that if, at any time, you and/or your child(ren) decide to cease participation in the Second Generation Project, you are free to do so. Your decision will have no impact on the status of your residence at the safe house.

Please note that the SGP curriculum is a targeted, time-limited, effective, therapeutic, and rewarding process. These sessions are not the same as The Center’s weekly support groups. It is hoped that you will attend the weekly support groups in addition to your participation in the SGP curriculum.

It is also hoped that, if your child feels the curriculum has been rewarding, he/she will be available to participate in follow-up “aftercare” sessions provided by The Center once your stay at the safe house has ended.

I have read and understand the above, it has been verbally explained to me by a counselor, and I voluntarily agree to participate in the SGP curriculum along with my child(ren) while I am in residence at the safe house.

________________________________________________________________________
Client Signature                                           Date

________________________________________________________________________
Counselor Signature                                      Date

[Rev: 2/11]
The Center for Violence-Free Relationships  
Second Generation Project  

~Progress Notes~

Client: ______________________________________

Date: ________________________________

Feedback: __________________________________________________________________________

____________________________________________________________________________________

Session: ______________________________________________________________________________

____________________________________________________________________________________

Intervention: __________________________________________________________________________

____________________________________________________________________________________

Client Assignment: ______________________________________________________________________

____________________________________________________________________________________

Therapist Follow-Up: _____________________________________________________________________

____________________________________________________________________________________

[Rev: 2/2011]
The Center for Violence-Free Relationships
Second Generation Project

~Client Log~

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[Rev: 2/2011]
APPENDIX E

Curriculum
The Center for Violence-Free Relationships  
Second Generation Project Lesson Plan – Session #1  
TF-CBT “PRACTICE” model letter “P” – for Psychoeducation

**SESSION #1**

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Safety First!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Subjects:</td>
<td>Introduction and Orientation</td>
</tr>
</tbody>
</table>
| Session Objectives: | ▪ Create Group Unity  
▪ Understand Components of TF-CBT  
▪ Learn Safety Rules for Group, School, and Home Environments  
▪ Learn the Children’s Bill of Rights  
▪ Understand What Boundaries Are and Why They Are Important  
▪ Understand Cultural Respect, Values, and Considerations |
<p>| Presenter: | Therapist |
| Facilitators: | Assistants |
| Time Duration: | 90 minutes |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
</tr>
</thead>
</table>
| Welcome                       | 20      | ■ Introductions  
■ Ice breaker  
■ Describe objectives for session  
■ Create group bonding  
■ Understand the components of TF-CBT and gradual process of trauma integration | ■ Introduce facilitators and group  
■ Ice breaker game  
■ Describe objectives for session  
■ Discuss components of TF-CBT and PRACTICE model | ■ Lecture  
■ Group participation and discussion | ■ Ice Breaker Game  
■ Handout: What is Safety?  
■ Text: Ice Breaker Book | ■ Easel  
■ Bill of Rights poster  
■ Procure interpreter for monolingual participants | Modify as needed for children with special needs |
| Opening Ritual/Icebreaker     | 10      | ■ Create unity                                                                   | ■ Teach/practice opening ritual (e.g., group cheer)                     | ■ Group Interaction                        | ■ Practice opening ritual  
■ Handout: Opening Ritual | | |
| Brain Gym                     | 5       | ■ Put group at ease  
■ Relax and oxygenate group                                                       | ■ Brain Gym exercises to music                                          | ■ Lecture  
■ Demonstration  
■ Group participation | ■ Brain Gym activities:  
-Cross-Crawl  
-Lazy 8’s | ■ CD player with speakers  
■ Appropriate music  
■ Text: Brain Gym | |
| Safety                        | 15      | ■ Learn safety rules and the structure of group, school, home environments  
■ Learn the Children’s Bill of Rights                                               | ■ What is a Shelter?  
■ Identify and define safety  
■ Bill of Rights | ■ Lecture  
■ Group discussion  
■ Group participation | ■ Draw a room/add safe objects, colors  
■ Text: Shelter Book & Tape  
■ Bill of Rights | ■ Art supplies  
■ Whiteboard  
■ Activity sheets  
■ Table of possible safety items  
■ Bill of Rights sheets | |

128
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
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</thead>
<tbody>
<tr>
<td>Snack Break</td>
<td>10</td>
<td>▪ Snacks and Juice</td>
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</tr>
<tr>
<td>Boundaries</td>
<td>10</td>
<td>▪ Understand what boundaries are and the importance of them</td>
<td>▪ What is a boundary?</td>
<td>Lecture</td>
<td>▪ Boundary demonstration - How close is too close?</td>
<td>Hula Hoops</td>
<td></td>
</tr>
<tr>
<td>▪ How do boundaries help us?</td>
<td></td>
<td>▪ Group interaction</td>
<td></td>
<td></td>
<td>(with hula hoops)</td>
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<tr>
<td>Cultural Considerations</td>
<td>10</td>
<td>▪ Understand cultural respect, values, and considerations</td>
<td>▪ What is respect?</td>
<td>Lecture</td>
<td>▪ We Are All Different; We Are All the Same</td>
<td>Paper bags</td>
<td>▪ Paper bags</td>
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<tr>
<td>▪ How do you show respect?</td>
<td></td>
<td>▪ Everyone deserves respect and kindness</td>
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<td>Various pictures from magazines</td>
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<td>Homework</td>
<td>5</td>
<td>▪ Introduce homework</td>
<td>▪ Read selected text during the week</td>
<td>Lecture</td>
<td></td>
<td>Selected text for shared reading</td>
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</tr>
<tr>
<td>▪ Introduce Positive Affirmations</td>
<td></td>
<td>▪ Repeat positive affirmations daily</td>
<td></td>
<td></td>
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<td>Handout: About Your Family</td>
<td></td>
</tr>
<tr>
<td>▪ Boundary and Respect skills</td>
<td></td>
<td>▪ Complete written handout</td>
<td></td>
<td></td>
<td></td>
<td>Positive affirmations</td>
<td></td>
</tr>
<tr>
<td>▪ Write down 5 times when you showed respect for someone else</td>
<td></td>
<td>▪ Lecture</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Wrap-up/Review/Closing Ritual</td>
<td>5</td>
<td>▪ Resolve unanswered questions</td>
<td>▪ Solicit and respond to questions</td>
<td>Lecture</td>
<td></td>
<td>Closing ritual</td>
<td></td>
</tr>
<tr>
<td>▪ Confirm objectives met</td>
<td></td>
<td>▪ Review objectives</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>▪ Closing ritual</td>
<td></td>
<td>▪ Repeat closing ritual</td>
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<td>Total Minutes</td>
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**SESSION #2**

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<thead>
<tr>
<th>Session Title:</th>
<th>Chill Out!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Subjects:</td>
<td>Relaxation, Stress Reduction</td>
</tr>
</tbody>
</table>
| Session Objectives: | - Learn Various Relaxation and Visualization Techniques  
|                     | - Learn about Stress Reduction         |
|                     | - Introduce the Power of Positive Thinking and Positive Self-Talk  
<p>|                     | - Introduce the Tool kit               |
| Presenter:          | Therapist                              |
| Facilitator:        | Assistants                             |
| Time Duration:      | 90 minutes                             |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome/Review</td>
<td>5</td>
<td>- Describe objectives for session</td>
<td>Re-introduce facilitators and group</td>
<td>Lecture</td>
<td>Chant Rights</td>
<td>Easel</td>
<td>Bill of Rights poster</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Review homework</td>
<td>Describe objectives for session</td>
<td>Group participation</td>
<td>Chant safety rules</td>
<td>List of safety rules</td>
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<tr>
<td></td>
<td></td>
<td>- Review Bill of Rights</td>
<td>Review homework</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Review Bill of Rights</td>
<td>Review Bill of Rights</td>
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<tr>
<td></td>
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<td>- Review safety rules for sessions</td>
<td>Review safety rules for sessions</td>
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<tr>
<td>Brain Gym</td>
<td>5</td>
<td>- Put group at ease</td>
<td>Brain Gym exercises to music</td>
<td>Lecture</td>
<td>Brain Gym activities: -Cross-Crawl -Lazy 8’s -Neck Rolls -The Elephant</td>
<td>CD player with speakers</td>
<td>Appropriate music</td>
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<tr>
<td></td>
<td></td>
<td>- Relax and oxygenate group</td>
<td></td>
<td>Demonstration</td>
<td></td>
<td>Text: Brain Gym</td>
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<td>Group participation</td>
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<tr>
<td>Relaxation</td>
<td>20</td>
<td>- Learn various relaxation techniques</td>
<td>Deep breathing</td>
<td>Lecture</td>
<td>Deep breathing exercise</td>
<td>Stuffed animals</td>
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<tr>
<td></td>
<td></td>
<td>- Learn breathing exercises</td>
<td>Controlled breathing</td>
<td>Demonstration</td>
<td>Lie on back with stuffed animal on tummy</td>
<td>Bottles of Soap Bubbles</td>
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<td></td>
<td></td>
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<td>Blow bubbles outside</td>
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<td>Blow bubbles outside</td>
<td>Appropriate music</td>
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<td></td>
<td></td>
<td></td>
<td>Muscle tension and release (Robot/rag doll)</td>
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<td>Floor mats</td>
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<td>Content</td>
<td>Delivery Approach</td>
<td>Activities</td>
<td>Materials</td>
<td>Notes / Adaptations Needed</td>
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<td>Stress Reduction</td>
<td>20</td>
<td>▪ Learn about stress reduction                                                    ▪ Learn what stress looks like                                         ▪ Share Stress-Busters list</td>
<td>▪ Describe symptoms of stress ▪ Group shares examples of personally stressful situations ▪ Select personal stress balls ▪ Review Stress-Busters list and brainstorm other ways to reduce stress ▪ What is a Tool Kit?</td>
<td>▪ Lecture ▪ Group interaction ▪ Group activity</td>
<td>▪ Share personal stories about stress ▪ Show sample of Tool Kit</td>
<td>▪ Tool Kit baskets ▪ Stress balls for Tool Kit</td>
<td>▪ The Tool Kit carrier will vary so child/adult can pick one that they like: baskets, etc.</td>
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<td>Snack Break</td>
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<td>▪ Snacks and Juice</td>
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<td>Creative Visualization</td>
<td>20</td>
<td>▪ Conduct a creative visualization exercise                                        ▪ Explore positive thoughts</td>
<td>▪ Select small stuffed animal ▪ Do Magic-Carpet-to-Safe-Place guided visualization exercise ▪ Meet selected animal as guide, friend, support ▪ Share animal guide with group ▪ Add small animal to Tool Kit ▪ Discuss safe place and positive thoughts experienced during visualization exercise</td>
<td>▪ Lecture ▪ Guided visualization ▪ Group share</td>
<td>▪ Guided visualization exercise</td>
<td>▪ Variety of small stuffed animals ▪ Floor mats</td>
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<td>Topic</td>
<td>Minutes</td>
<td>Topic Objectives</td>
<td>Content</td>
<td>Delivery Approach</td>
<td>Activities</td>
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<td>Positive Affirmations</td>
<td>5</td>
<td>• Introduce the power of positive thinking and positive self-talk</td>
<td>• Explain purpose and structure of positive affirmations</td>
<td>Lecture</td>
<td>Brainstorm session</td>
<td>Easel</td>
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<tr>
<td></td>
<td></td>
<td>• Create personal positive affirmations/soothing self-talk</td>
<td>• Brainstorm various affirmations and write on easel</td>
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<td>• Group share</td>
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<td>• Brainstorm session</td>
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<td>• Easel</td>
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<td>Homework</td>
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<td>• Introduce homework</td>
<td>• Read selected book during the week</td>
<td>Lecture</td>
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<td>• Use stress balls</td>
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<td>• Repeat positive affirmations daily</td>
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<td>• Complete written handout</td>
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<td>• Selected text for shared reading</td>
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<td>• Handouts: -Relaxation Practice</td>
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<td>• Handouts: -Draw All Special Things</td>
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<tr>
<td>Wrap-up/Review/</td>
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<td>• Resolve unanswered questions</td>
<td>• Solicit and respond to questions</td>
<td>Lecture</td>
<td>Closing ritual</td>
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<tr>
<td>Closing Ritual</td>
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<td>• Confirm objectives met</td>
<td>• Review objectives</td>
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<td>• Closing ritual</td>
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| Total Minutes | 90   |                                                                                       |                                                                         |                   |              |           |                             |
# SESSION #3

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Don’t Worry – Be Happy!</th>
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<tbody>
<tr>
<td>Session Subjects:</td>
<td>Emotions and Positive Feelings</td>
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</tbody>
</table>
| Session Objectives:    | - Learn to Identify/ Distinguish Different Feelings  
                          - Introduce How to Express Upsetting Feelings; Reframe Feelings  
                          - Learn How to Enjoy Positive Feelings  
                          - Learn How to Experience Simultaneous Feelings |
<p>| Presenter:             | Therapist               |
| Facilitator:           | Assistants              |
| Time Duration:         | 90 minutes              |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening ritual/Icebreaker</td>
<td>5</td>
<td>▪ Break the ice</td>
<td>▪ Do opening ritual</td>
<td>▪ Group activity</td>
<td>▪ Opening ritual</td>
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<tr>
<td>Welcome/Review</td>
<td>10</td>
<td>▪ Describe objectives for session</td>
<td>▪ Describe objectives for session</td>
<td>▪ Lecture</td>
<td>▪ Chant Rights</td>
<td>▪ Easel</td>
<td>▪ Bill of Rights poster</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Review homework</td>
<td>▪ Review homework</td>
<td></td>
<td></td>
<td>▪ List of safety rules</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>▪ Reaffirm Bill of Rights</td>
<td>▪ Review Bill of Rights</td>
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<tr>
<td></td>
<td></td>
<td>▪ Reaffirm safety rules</td>
<td>▪ Review safety rules for session</td>
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<tr>
<td></td>
<td></td>
<td>▪ Relaxation</td>
<td>▪ Review relaxation exercises</td>
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<tr>
<td>Brain Gym</td>
<td>5</td>
<td>▪ Put group at ease</td>
<td>▪ Brain Gym exercises to music</td>
<td>▪ Demonstration</td>
<td>▪ Brain Gym: -Cross-Crawl</td>
<td>▪ CD player with speakers</td>
<td>▪ Appropriate music</td>
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<td>▪ Relax and oxygenate group</td>
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<td>-Lazy 8’s -Neck Rolls -The Elephant</td>
<td>▪ Text: Brain Gym</td>
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<td></td>
<td></td>
<td>▪ List feelings</td>
<td>▪ List various feelings identified in the story</td>
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<td>▪ Feelings Charades game</td>
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<td>Snack Break</td>
<td>10</td>
<td>▪ Snacks and Juice</td>
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<td>Feelings – Activities</td>
<td>20</td>
<td>▪ Tap into variety of personal feelings</td>
<td>▪ Read: <em>A Volcano in My Tummy</em></td>
<td>▪ Storytelling</td>
<td>▪ Feelings Jar worksheet</td>
<td>▪ Text: <em>A Volcano in My Tummy</em></td>
<td>▪ Feelings Jar, Anger Styles worksheets</td>
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<td></td>
<td></td>
<td>▪ Learn outlets for angry feelings</td>
<td>▪ Complete: Feelings Jar worksheet</td>
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<td>▪ Feelings Jar Worksheets</td>
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<td>▪ Act out feelings</td>
<td>▪ Complete: Anger Styles worksheet</td>
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<td>▪ Anger Styles worksheets</td>
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<td></td>
<td></td>
<td>▪ Identify anger styles</td>
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<td>▪ Anger Styles worksheets</td>
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</tbody>
</table>

- List all negative feelings, put them in a Feelings Jar, and throw it away.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings – Lecture</td>
<td>15</td>
<td>- Learn about consequences of unexpressed/unidentified feelings</td>
<td>- Discuss how feelings fester if not released</td>
<td>Lecture</td>
<td>Write “Happy” list</td>
<td>Pen</td>
<td>Paper</td>
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<tr>
<td></td>
<td></td>
<td>- Identify positive feelings</td>
<td>- List “5 Things That Make Me Happy”</td>
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<td>Paper</td>
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<td></td>
<td></td>
<td>- Identify multiple simultaneous feelings</td>
<td>- Describe how we can feel 2 feelings at the same time</td>
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<td>Homework</td>
<td>5</td>
<td>- Introduce homework</td>
<td>- Read selected book during the week</td>
<td>Lecture</td>
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<td>- Review positive affirmations</td>
<td>- Use stress balls</td>
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<td>- Repeat positive affirmations daily</td>
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<td></td>
<td>- Complete written handouts</td>
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<tr>
<td>Wrap-up/Review/</td>
<td>5</td>
<td>- Resolve unanswered questions</td>
<td>- Solicit and respond to questions</td>
<td>Discussion</td>
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<td>Closing Ritual</td>
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<td>- Confirm objectives met</td>
<td>- Review objectives</td>
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<td></td>
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<td>- Closing ritual</td>
<td>- Repeat closing ritual</td>
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## SESSION #4

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<tr>
<th>Session Title:</th>
<th>Think It! Feel It! Do It!</th>
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<tbody>
<tr>
<td>Session Subject(s):</td>
<td>Cognitive Coping (Positive Thinking, Mindfulness), Cognitive Triangle</td>
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</table>
| Session Objective(s): | - Introduce the Cognitive Triangle  
- Learn the Connection Among Thoughts, Feelings, and Behaviors  
- Introduce How to Minimize Negative Thoughts  
- Decrease Impulsivity and Problems with Self-Regulation (Mindfulness Skills)  
- Reduce Dissociation and Depersonalization (Grounding Skills)  
- Increase Awareness of One’s Thoughts, Including Internal Dialogue  
- Understand That We Are in Charge of Our Own Thoughts and Feelings |
<p>| Presenter: | Therapist |
| Facilitator: | Assistants |
| Time Duration: | 90 minutes |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening ritual/Icebreaker</td>
<td>5</td>
<td>• Break the ice</td>
<td>• Do opening ritual</td>
<td>• Group activity</td>
<td>• Opening ritual</td>
<td>• Easel</td>
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</tr>
<tr>
<td>Welcome/Review</td>
<td>5</td>
<td>• Describe objectives for session • Review homework • Reaffirm Bill of Rights • Reaffirm Safety rules • Feelings</td>
<td>• Describe objectives for session • Review homework • Review Bill of Rights • Review safety rules for sessions • Review feeling identifiers</td>
<td>• Lecture • Group participation</td>
<td>• Chant Rights • Chant safety rules</td>
<td>• Easel • Bill of Rights poster • List of safety rules</td>
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<tr>
<td>Brain Gym</td>
<td>5</td>
<td>• Put group at ease • Relax and oxygenate group</td>
<td>• Brain Gym exercises to music</td>
<td>• Demonstration • Group participation</td>
<td>• Brain Gym activities: - Cross-Crawl - Lazy 8’s - Neck Rolls - The Elephant</td>
<td>• CD player with speakers • Appropriate music • Text: Brain Gym</td>
<td></td>
</tr>
<tr>
<td>Thoughts/Stories</td>
<td>10</td>
<td>• Identify/distinguish different thoughts • Connect thoughts with behaviors • Connect thoughts with feelings</td>
<td>• Read text: <em>The Boy Who Didn’t Want to be Sad</em> • Brainstorm alternative behaviors to character’s thoughts and feelings</td>
<td>• Lecture/story • Storytelling • Group activity</td>
<td>• Brainstorm session</td>
<td>• Easel • Markers • Text: <em>The Boy Who Didn’t Want to be Sad</em></td>
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</tr>
<tr>
<td>Topic</td>
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<td>Topic Objectives</td>
<td>Content</td>
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<td>Activities</td>
<td>Materials</td>
<td>Notes / Adaptations Needed</td>
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<td>Cognitive Triangle</td>
<td>20</td>
<td>- Introduce the Cognitive Triangle</td>
<td>- Distinguish between thoughts, feelings, and behaviors</td>
<td>Lecture</td>
<td>Play Emotion Triangle game</td>
<td>Easel, Markers</td>
<td>Handout: Thoughts/Feelings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Learn that we are in charge of our own thoughts and feelings</td>
<td>- Understand that we are in charge of our own thoughts and feelings</td>
<td>Group discussion</td>
<td>Complete Thoughts &amp; Feelings worksheet</td>
<td>Emotion Triangle scenarios and cards</td>
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<td>Handout: Thoughts/Feelings</td>
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<td>Snack Break</td>
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<td>- Snacks and Juice</td>
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<tr>
<td>Mindfulness</td>
<td>15</td>
<td>- Minimize distracting thoughts using mindfulness skills</td>
<td>- Practice mindfulness skills (E.g., eating, walking, counting backwards)</td>
<td>Lecture</td>
<td>Mindfulness skills, e.g., Mindful eating with M&amp;Ms; mindful walking</td>
<td>M&amp;Ms, Scented candles, Pictures, Music, Mints</td>
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<tr>
<td></td>
<td></td>
<td>- Explore grounding skills</td>
<td>- Improve grounding skills (E.g., engage all five senses)</td>
<td>Group activity</td>
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<tr>
<td>Positive Thinking</td>
<td>10</td>
<td>- Reframe negative thoughts to positive thoughts</td>
<td>- Identify negative thoughts and brainstorm alternative, more helpful/more accurate thoughts</td>
<td>Discussion</td>
<td>Brainstorm session</td>
<td></td>
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<td></td>
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<td>- Do activity to identify positive vs. negative thoughts</td>
<td>Group share</td>
<td></td>
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<td>5</td>
<td>- Introduce homework</td>
<td>- Read selected book during the week</td>
<td>Lecture</td>
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<td>Selected text, Handouts: I Like Myself A to Z, Self-Esteem, Whooo Am I?</td>
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<td></td>
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<td></td>
<td>- Practice mindful activities</td>
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<td>- Complete written handouts</td>
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<tr>
<td>Topic</td>
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<td>Topic Objectives</td>
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<td>Activities</td>
<td>Materials</td>
<td>Notes / Adaptations Needed</td>
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<td>Wrap-up/Review/ Closing Ritual</td>
<td>5</td>
<td>▪ Resolve unanswered questions</td>
<td>▪ Solicit and respond to questions</td>
<td>▪ Discussion</td>
<td>▪ Closing ritual</td>
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<td></td>
<td></td>
<td>▪ Confirm objectives met</td>
<td>▪ Review objectives</td>
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<td>▪ Closing ritual</td>
<td>▪ Repeat closing ritual</td>
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<td>Total Minutes</td>
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The Center for Violence-Free Relationships  
Second Generation Project Lesson Plan – Session #5  
TF-CBT “PRACTICE” model letter “T” – for Trauma Narrative Development and Processing  
**SESSION #5**  
<table>
<thead>
<tr>
<th><strong>Session Title:</strong></th>
<th>Everyone Has a Story</th>
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<tbody>
<tr>
<td><strong>Session Subjects:</strong></td>
<td>Personal Story (Trauma Narrative) and Communication</td>
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| **Session Objectives:** | • Identify Benefits of Direct Discussion of Traumatic Events  
• Explore Communication Techniques  
• Promote Open Communication |
<p>| <strong>Presenter:</strong> | Therapist |
| <strong>Facilitator:</strong> | Assistants |
| <strong>Time Duration:</strong> | 90 minutes |</p>
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<tr>
<td>Opening ritual/Icebreaker</td>
<td>5</td>
<td>- Break the ice</td>
<td>- Do opening ritual</td>
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<td>- Lecture</td>
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<td>- Easel</td>
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<td>- List of safety rules</td>
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<td>- Reaffirm Bill of Rights</td>
<td>- Review Bill of Rights</td>
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<td>- Reaffirm safety rules</td>
<td>- Review safety rules for session</td>
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<td>- Review relaxation exercises</td>
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<td>- Put group at ease</td>
<td>- Brain Gym exercises</td>
<td>- Lecture</td>
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<td>- Balance Buttons</td>
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<td>Introduction of Trauma Narrative</td>
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<td>- Identify benefits of direct discussion of traumatic events</td>
<td>- Neutral story of a traumatic event for practice</td>
<td>- Lecture</td>
<td>- Read text</td>
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<td>- Text: - Mommy and Daddy are Fighting</td>
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<td>- Snacks and Juice</td>
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<td>Read selected book during the week</td>
<td>Lecture</td>
<td>Lecture</td>
<td>Selected text for shared reading</td>
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<td>Repeat positive affirmations daily</td>
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<td>Complete written handouts</td>
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<td>- Feelings</td>
<td>- No one is an “I” Land</td>
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<tr>
<td>Wrap-up/Review/ Closing Ritual</td>
<td>5</td>
<td>Resolve unanswered questions</td>
<td>Solicit and respond to questions</td>
<td>Lecture</td>
<td>Lecture</td>
<td>Closing ritual</td>
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<td>Review objectives</td>
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<td>Closing ritual</td>
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The Center for Violence-Free Relationships  
Second Generation Project Lesson Plan – Session #6  
TF-CBT “PRACTICE” model letter “I” – for In Vivo Mastery of Trauma Reminders

SESSION #6

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Tell It Like It Is!</th>
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<tbody>
<tr>
<td>Session Subject:</td>
<td>Trauma Triggers</td>
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</table>
| Session Objectives:    | • Explore Trauma Triggers and Self-Care Techniques  
<pre><code>                    | • Explore Ways to Face One’s Fear         |
</code></pre>
<p>| Presenter:             | Therapist                               |
| Facilitator:           | Assistants                              |
| Time Duration:         | 90 minutes                              |</p>
<table>
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<tr>
<th>Topic</th>
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<td>5</td>
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<td>Do opening ritual</td>
<td>Group activity</td>
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<td>Easel</td>
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<td>Describe objectives for session</td>
<td>Describe objectives for session</td>
<td>Lecture</td>
<td>Chant Rights</td>
<td>Easel, Bill of Rights poster</td>
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<td>Review homework</td>
<td>Group participation</td>
<td>Chant safety rules</td>
<td>List of safety rules</td>
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<td>Review Bill of Rights</td>
<td>Review Bill of Rights</td>
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<td>Review Thoughts and Behaviors</td>
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<tr>
<td>Brain Gym</td>
<td>5</td>
<td>Put group at ease</td>
<td>Brain Gym exercises to music</td>
<td>Demonstration</td>
<td>Brain Gym activities:</td>
<td>CD player with speakers, Appropriate music</td>
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<td>Relax and oxygenate group</td>
<td>Group participation</td>
<td>Group participation</td>
<td>-Lazy 8’s -Thinking</td>
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<td>Cap -Balance Buttons</td>
<td>Text: Brain Gym</td>
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<td>Trauma triggers and self-care tech</td>
<td>30</td>
<td>Overcome avoidance</td>
<td>Generalized avoidance</td>
<td>Lecture</td>
<td>Brainstorm self-care</td>
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<td>Cope with trauma triggers</td>
<td>Trauma reminders/triggers/cues</td>
<td>Group discussion</td>
<td>techniques</td>
<td>Markers</td>
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<td></td>
<td>Introduce self-care techniques</td>
<td>Self-care techniques</td>
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<td>Snack and Juice</td>
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<td>Fear</td>
<td>25</td>
<td>Explore ways to face one’s fear</td>
<td>Text: <em>When I Feel Scared</em></td>
<td>Group discussion</td>
<td>Read text, Fear Activity</td>
<td>Text: - <em>When I Feel Scared</em> 3x5 cards</td>
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<td></td>
<td></td>
<td></td>
<td>What are common fears?</td>
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<td>Pencils</td>
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<td>Why do I feel fear?</td>
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<tr>
<td>Topic</td>
<td>Minutes</td>
<td>Topic Objectives</td>
<td>Content</td>
<td>Delivery Approach</td>
<td>Activities</td>
<td>Materials</td>
<td>Notes / Adaptations Needed</td>
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<td>Homework</td>
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<td>▪ Introduce homework</td>
<td>▪ Read selected text during the week</td>
<td>Lecture</td>
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<td>▪ Selected text for shared reading</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Use stress balls</td>
<td></td>
<td></td>
<td>▪ Handouts: -Guardian Angel</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Repeat positive affirmations daily</td>
<td></td>
<td></td>
<td>-Your Fabulous Future</td>
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<td></td>
<td></td>
<td>▪ Complete written handout</td>
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<tr>
<td>Wrap-up/Review/</td>
<td>5</td>
<td>▪ Resolve unanswered questions</td>
<td>▪ Solicit and respond to questions</td>
<td>Discussion</td>
<td></td>
<td>▪ Closing ritual</td>
<td></td>
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<tr>
<td>Closing Ritual</td>
<td></td>
<td>▪ Confirm objectives met</td>
<td>▪ Review objectives</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>▪ Closing ritual</td>
<td>▪ Repeat closing ritual</td>
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## Session #7

**Session Title:** I’m Listening!

**Session Subject:** Personal Story (Trauma Narrative) – Child-Parent Share

<table>
<thead>
<tr>
<th>Session Objectives</th>
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</thead>
<tbody>
<tr>
<td>• Review Personal Story with Child</td>
</tr>
<tr>
<td>• Address Child’s Concerns Regarding Sharing Personal Story</td>
</tr>
<tr>
<td>• Create Quiz for Mother (optional)</td>
</tr>
<tr>
<td>• Review Personal Story with Mother</td>
</tr>
<tr>
<td>• Address Mother’s Concerns Regarding Hearing Personal Story</td>
</tr>
<tr>
<td>• Review Quiz With Mother (optional)</td>
</tr>
<tr>
<td>• Complete Personal Story Share</td>
</tr>
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</table>

**Presenter:** Therapist

**Facilitator:** Assistants

**Time Duration:** 60-90 minutes
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD ONLY Opening Check-In</td>
<td>5</td>
<td>Reduce anxiety</td>
<td>Child shares affective status, concerns</td>
<td>Discussion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Story</td>
<td>15</td>
<td>Review Personal Story</td>
<td>Have child read Personal Story, Address any concerns about sharing story with mother</td>
<td>Discussion</td>
<td>Story review</td>
<td>Completed Personal Story</td>
<td></td>
</tr>
<tr>
<td>Quiz (Optional)</td>
<td>10</td>
<td>Create Quiz</td>
<td>Solicit 3 questions that child wants to ask mother after Personal Story is shared</td>
<td>Brainstorm session</td>
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<td></td>
<td>Note pad and pen</td>
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<tr>
<td>MOTHER ONLY Opening Check-In</td>
<td>5</td>
<td>Reduce anxiety</td>
<td>Mother shares affective status, concerns</td>
<td>Discussion</td>
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</tr>
<tr>
<td>Personal Story</td>
<td>15</td>
<td>Review Personal Story</td>
<td>Read Personal Story to mother, Address any concerns about hearing story from child</td>
<td>Discussion</td>
<td>Story review</td>
<td>Completed Personal Story</td>
<td></td>
</tr>
<tr>
<td>Quiz (Optional)</td>
<td>10</td>
<td>Review Quiz</td>
<td>Prepare Comments, Share quiz with mother, Make sure mother can answer questions supportively and appropriately, Help mother phrase any questions/comments she has for the child</td>
<td>Discussion</td>
<td></td>
<td></td>
<td>Note pad and pen</td>
</tr>
<tr>
<td>CHILD/PARENT CONJOINT SESSION Ice Breaker</td>
<td>5</td>
<td>Put Mother/Child at Ease</td>
<td>Do short relaxation exercise with mother/child to help them relax and prepare for the story share</td>
<td>Narrative</td>
<td></td>
<td>Guided relaxation activity</td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Minutes</td>
<td>Topic Objectives</td>
<td>Content</td>
<td>Delivery Approach</td>
<td>Activities</td>
<td>Materials</td>
<td>Notes / Adaptations Needed</td>
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</tr>
</tbody>
</table>
| Personal Story | 25     | ▪ Share Personal Story | ▪ Have child read Personal Story to mother  
▪ Have child administer quiz to mother (optional)  
▪ Praise child for bravery  
▪ Encourage questions or comments from mother  
▪ Resolve unanswered questions | ▪ Recitation  
▪ Discussion | ▪ Story share  
▪ Group share | ▪ Note pad and pen  
▪ Completed Personal Story |
| Total Minutes | 90     |                 |                                                                      |                   |            |                            |                           |
The Center for Violence-Free Relationships  
Second Generation Project Lesson Plan – Session #8  
TF-CBT “PRACTICE” model letter “E” – for Enhancing Future Safety and Development

**SESSION #8**

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>I Am Special!</th>
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</thead>
<tbody>
<tr>
<td>Session Subjects:</td>
<td>Safety Plan, Personal Awareness, Confident Body Language, Celebration</td>
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</table>
| Session Objectives:    | • Identify and Create a Safety Plan  
                        | • Increase External Safety Awareness 
                        | • Increase Internal Safety Awareness 
                        | • Practice Confident Body Language 
<pre><code>                    | • Celebrate Accomplishments |
</code></pre>
<p>| Presenter:             | Therapist                            |
| Facilitator:           | Assistants                           |
| Time Duration:         | 90 minutes + Party                   |</p>
<table>
<thead>
<tr>
<th>Topic</th>
<th>Minutes</th>
<th>Topic Objectives</th>
<th>Content</th>
<th>Delivery Approach</th>
<th>Activities</th>
<th>Materials</th>
<th>Notes / Adaptations Needed</th>
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</thead>
<tbody>
<tr>
<td>Opening ritual/Icebreaker</td>
<td>5</td>
<td>▪ Break the ice</td>
<td>▪ Do opening ritual</td>
<td>▪ Group activity</td>
<td>▪ Opening ritual</td>
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<tr>
<td>Welcome/Review</td>
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<td>▪ Describe objectives for session</td>
<td>▪ Describe objectives for session</td>
<td>▪ Lecture</td>
<td>▪ Chant Rights</td>
<td>▪ Easel</td>
<td>▪ Bill of Rights poster ▪ List of safety Rules</td>
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<tr>
<td></td>
<td></td>
<td>▪ Review Bill of Rights</td>
<td>▪ Review Bill of Rights</td>
<td>▪ Group participation</td>
<td>▪ Chant safety Rules</td>
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<tr>
<td></td>
<td></td>
<td>▪ Safety rules</td>
<td>▪ Review Safety Rules</td>
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<td></td>
<td></td>
<td>▪ Feelings</td>
<td>▪ Describe objectives for session</td>
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<td>▪ Feelings</td>
<td>▪ Review Bill of Rights</td>
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<td>▪ Feelings</td>
<td>▪ Review Safety Rules</td>
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<td>▪ Feelings</td>
<td>▪ Describe objectives for session</td>
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<td>▪ Feelings</td>
<td>▪ Review Bill of Rights</td>
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<td>▪ Feelings</td>
<td>▪ Review Safety Rules</td>
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<td>Brain Gym</td>
<td>5</td>
<td>▪ Put group at ease</td>
<td>▪ Brain Gym exercises to music</td>
<td>▪ Demonstration</td>
<td>▪ Brain Gym activities:</td>
<td>▪ CD player with speakers</td>
<td>▪ Appropriate music ▪ Text: Brain Gym</td>
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<td>▪ Relax and oxygenate group</td>
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<td>▪ Group participation</td>
<td>-Cross Crawl</td>
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<td>-Lazy 8’s</td>
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<td>-Thinking Cap</td>
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<td>-Balance Buttons</td>
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<td>Safety Plan</td>
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<td>▪ Identify effective Safety Plan</td>
<td>▪ Go to a safe place</td>
<td>▪ Lecture/Discussion</td>
<td>▪ Brainstorm session</td>
<td>▪ Easel</td>
<td>▪ Markers ▪ Crayons ▪ Safe Place handout</td>
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<td>▪ Identify effective Safety Plan</td>
<td>▪ Contact a supportive adult</td>
<td>▪ Brainstorm session</td>
<td>▪ Complete Safe Place handout</td>
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<td>▪ Identify effective Safety Plan</td>
<td>▪ Call 911</td>
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<td>▪ Review safe rules</td>
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<td>▪ “Safe Place” handout</td>
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<td>▪ Identify effective Safety Plan</td>
<td>▪ Create list of safe/unsafe people and places</td>
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<td></td>
<td>▪ Identify effective Safety Plan</td>
<td>▪ Describe and demonstrate appropriate</td>
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<td></td>
<td></td>
<td>▪ Identify effective Safety Plan</td>
<td>boundaries</td>
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<td>▪ Identify effective Safety Plan</td>
<td>▪ Lecture</td>
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<td></td>
<td>▪ Identify effective Safety Plan</td>
<td>▪ Group discussion</td>
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<td>External Safety Awareness</td>
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<td>▪ Brainstorm safe/unsafe people/places</td>
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<td>▪ Easel</td>
<td>▪ Markers ▪ Handout: Enhancing Safety</td>
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<tr>
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<td></td>
<td>▪ Identify safe/unsafe places</td>
<td>▪ Describe and demonstrate appropriate</td>
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<tr>
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<td>▪ Identify safe/unsafe places</td>
<td>boundaries</td>
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<td>▪ Identify safe/unsafe places</td>
<td>▪ Lecture</td>
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<td>▪ Group discussion</td>
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<td>▪ Identify safe/unsafe places</td>
<td>▪ Brainstorm safe/unsafe people/places</td>
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<td>Snack Break</td>
<td>5</td>
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<td>Minutes</td>
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<td>Notes / Adaptations Needed</td>
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</tbody>
</table>
| Internal Safety Awareness/ Confident Body Language | 15      | - Identify awareness of thoughts, feelings, values  
- Make verbal and nonverbal communication congruent | - Describe how to communicate thoughts, feelings  
- Practice the following: Look a person in the eye, confident body posture, firm voice, tell the person what you want | Lecture           | Group activity                       | Demonstrate with puppets  
Practice confident body language | Notes / Adaptations Needed | |
| Favorite Things                            | 10      | - Create list of favorite things                      | - Brainstorm favorite things for easel  
- Make list/draw pictures of favorite things/safe places for tool kit | Group activity    | Create list/draw pictures of favorite things | Magic markers  
Crayons  
Paper | |
| Tool Kits                                  | 10      | - Complete items for tool kit                         | - Take photo of each child to place on cover of Personal Story or into tool kit  
- Add crayons, pencils to tool kits | Group activity    | Take photos of each child             | Camera  
Crayons  
Pencils  
Misc. items for tool kits | |
| Closing Ritual                             | 5       | - Resolve unanswered questions  
- Closing ritual                                   | - Repeat closing ritual                                           | Group activity    | Closing ritual                       |                         | |
| Celebration                                | Varies  | - Celebrate accomplishments                           | - Have a party!                                                   | Party             |                                      | Cake  
Drinks  
Music  
Favorite foods | |
| Total Minutes                              | 90 + party | | | | | | |
APPENDIX F

Program Evaluations
The Center for Violence-free Relationships
Second Generation Project

Pre-Test / Post-Test
(Circle One)

NAME ________________________  DATE ________________________

1. When you have upsetting experiences, list up to five things you can do to help yourself relax [For example, close your eyes, breathe slowly]:

1. __________________________________________________________ 
2. __________________________________________________________ 
3. __________________________________________________________ 
4. __________________________________________________________ 
5. __________________________________________________________ 

2. When you feel unsafe, list up to five things you can do to make yourself feel safer:

1. __________________________________________________________ 
2. __________________________________________________________ 
3. __________________________________________________________ 
4. __________________________________________________________ 
5. __________________________________________________________ 

3. There are healthy ways and unhealthy ways to make yourself feel better when you feel upset or afraid. Circle all the ways that are healthy:

- Bite your nails
- Drink water
- Talk to a friend
- Yell at your mom
- Leave the room where you feel afraid
- Eat sugary foods
- Take slow, deep breaths
- Cut school
- Talk to an adult that you trust
4. Please identify whether each item is a thought, feeling, or action, by placing an “X” in the appropriate box:

<table>
<thead>
<tr>
<th>#</th>
<th>ITEM</th>
<th>THOUGHT</th>
<th>FEELING</th>
<th>ACTION</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Happy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Running</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I’m smart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hitting</td>
<td></td>
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<tr>
<td>5</td>
<td>They don’t like me</td>
<td></td>
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<tr>
<td>6</td>
<td>Sad</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Playing</td>
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<td></td>
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<tr>
<td>8</td>
<td>Mad</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>I can do it</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td>It’s my fault</td>
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<tr>
<td>11</td>
<td>Worried</td>
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<tr>
<td>12</td>
<td>Hiding</td>
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<td>13</td>
<td>Crying</td>
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<td>14</td>
<td>Singing</td>
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<tr>
<td>15</td>
<td>Lonely</td>
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<tr>
<td>16</td>
<td>She’s mad at me</td>
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<tr>
<td>17</td>
<td>Eating ice cream</td>
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<tr>
<td>18</td>
<td>Excited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I feel safe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Taking a walk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Scared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Taking a deep breath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I’ll be okay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Hopping on one foot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Brave</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Talking to a friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I feel like singing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Safe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from Rose-Walsh & Hendricks, 2010)
5. List as many feelings as you can think of, up to ten:
   1. _________________________________________________________
   2. _________________________________________________________
   3. _________________________________________________________
   4. _________________________________________________________
   5. _________________________________________________________
   6. _________________________________________________________
   7. _________________________________________________________
   8. _________________________________________________________
   9. _________________________________________________________
  10. _________________________________________________________

6. When you feel scared, list up to five things you feel inside your body
[For example, your palms get sweaty or your shoulders tense up]:
   1. __________________________________________________________
   2. __________________________________________________________
   3. __________________________________________________________
   4. __________________________________________________________
   5. __________________________________________________________

7. List two people you can call or go to if you feel unsafe:
   1. __________________________________________________________
   2. __________________________________________________________

8. If you listed anyone above, please write down their address or phone number:
   1. __________________________________________________________
   2. __________________________________________________________
9. When you hear two people yelling at each other, what do you do to make yourself feel safe?

1. _________________________________________________________

2. _________________________________________________________

10. Please finish the following sentence by circling the choice that seems right to you:

When I hear people argue

1. It is usually my fault.

2. I should try to break it up.

3. I should leave the room.

11. Please finish the following sentence by circling the choice that seems right to you:

When someone, either a stranger or someone I know, makes me feel uncomfortable, I should

1. Do what he/she says so that I don’t disobey.

2. Go and tell an adult I trust.

3. Tell a friend.

Thank you!

[Rev: 2/2011]
The Center for Violence-free Relationships  
Second Generation Project – TF-CBT  
Curriculum  
(To be Filled out by Child)

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Sessions 1-8</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator:</td>
<td>Therapist</td>
<td></td>
</tr>
<tr>
<td>Co-Facilitators:</td>
<td>Assistants</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agree A Lot</th>
<th>Only Agree A Little</th>
<th>Don’t Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At the beginning of these classes, the teachers explained to me why it was important for me to participate in them.

At the beginning of these classes, the teachers explained some of the things I was going to learn.

In general, my knowledge about thoughts, feelings, and behaviors has increased since I started these classes.

I have enjoyed being in the classes with other kids.

**Please let us know how you felt about the activities you did in**

- the movies we watched.
- the books we read.
- the opening and closing rituals.
- the breathing exercises.
- the arts & crafts.
- filling my Tool Kit.
- doing my homework between classes.
- my individual sessions with the counselor.

I liked working with all the adults who helped us out during the

I look forward to participating in more of these classes.

Overall, I am glad that I participated in these classes.
Please complete the following sentences:

The activities I liked doing the most were:


The activities I liked doing the least were:


The things I enjoyed learning about the most were:


The things I did not enjoy learning about were:


My favorite item in my Tool Kit is:


[Rev: 3/11-aae]
**The Center for Violence-free Relationships Second Generation Project – TF-CBT Curriculum**

(To be Filled out by Mother)

<table>
<thead>
<tr>
<th>Session Title:</th>
<th>Sessions 1-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator:</td>
<td>Therapist</td>
</tr>
<tr>
<td>Co-Facilitators:</td>
<td>Assistants</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The curriculum objectives were clearly stated and easily understood.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The curriculum met nearly all of the stated objectives.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>In general, my knowledge and skills increased as a result of this curriculum.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The supplies and equipment used for the curriculum were favorable to learning.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The curriculum materials (handouts, homework) were appropriate and easy to use.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There was enough time between sessions to practice the activities and learn the material.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The curriculum leaders knew the material and were well prepared to teach the sessions.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The curriculum leaders related well to my child.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The curriculum leaders related well to me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The curriculum leaders matched my learning style.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Overall, I was satisfied with the curriculum.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Please enter comments you may have in the sections below:

What should we put in place to improve this program?
(Something we should **START**)

What did we do in this program that did not work for you?
(Something we should **STOP**)

What is working well in this program that should be continued?
(Something we should **CONTINUE**)

What other feedback would you like to give to the curriculum leaders about your experience?

[Rev: 3/11-aae]
APPENDIX G

Myths and Stereotypes about Domestic Violence
MYTHS AND STEREOTYPES

• Nobody should interfere in domestic affairs.

• Domestic violence only occurs in poor or ‘problem’ families.

• Only drunks, drug users, or ‘macho’ men are perpetrators of domestic violence.

• She must ask for it/provoke it/deserve it/enjoy it.

• Relationship violence affects only a small part of the population.

• Domestic violence occurs only among poorly educated families in the lower socio-economic classes.

• Domestic violence is usually a one-time, isolated occurrence.

• Fights between mates are a natural part of life. Men have a right to discipline their wives – it’s not a crime.

• Domestic violence is an issue for minorities, not white people.

• Abused women must like it; otherwise, they would leave the guy.

• Women are just as violent as men.

• Battering occurs only in heterosexual relationships.

(Adapted from Clark County, 2011; Turning Point Services, n.d.)
REFERENCES


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*Australian violence: Contemporary perspectives II* (pp. 253-270). Canberra,

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