HELPING TO HEAL THE EFFECTS OF TRAUMA IN YOUNG CHILDREN AT
THE MULTIPLE ASSISTANCE CENTER (MAC) THROUGH GROUP
EDUCATION

By

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Abstract

HELPING TO HEAL THE EFFECTS OF TRAUMA IN YOUNG CHILDREN AT THE MULTIPLE ASSISTANCE CENTER (MAC) THROUGH GROUP EDUCATION

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This project developed a 12-week curriculum to address the impacts of trauma on the early development of children and provide tools for parents to help their children better cope with and heal from the effects of trauma at the Redwood Community Action Agency’s Multiple Assistance Center (RCAA/MAC), a transitional living facility for homeless families. The curriculum was developed with input from the families living at the MAC and MAC staff. Seeking and utilizing input from the families living at the MAC empowers clients to have a voice within the process of creating the curriculum.
Acknowledgements

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Introduction

Homelessness is a prevalent issue in the U.S. today and it is especially so for families. Based on a conservative estimate using a point-in-time count from 2010, HUD estimated 650,000 people in a single night that were homeless, 242,000 (37%) who were in families (Buckner, 2014). In addition, there has been a nearly 20% increase in the number of people in homeless families from 2007 to 2010 due to the Great Recession (Buckner, 2014). Homeless families now comprise the greatest percentage of the homeless population in the recorded history of the U.S. (Buckner, 2014).

Although certain subpopulations such as single adults with chronic housing instability have recently decreased, the subpopulation of homeless families is predicted to continue increasing due to worsening economic conditions for those already in poverty (Cowan, 2014). The who and why of homelessness is largely determined by the structural imbalance of supply and demand for homes as well as the specific factors that determine who is at greatest risk of being homeless (Buckner, 2014). California ranks 48th worst out of 50 states in homelessness of its children, based on the domains of the number of children experiencing homelessness, risk for child homelessness, child well-being, and state planning and policy efforts (Bassuk, DeCandia, Beach, & Berman, 2014). In our local context of Humboldt County, the decreasing supply of transitional living opportunities contributes to the growing problem of the structural imbalance between housing supply and demand for families.
The effect of childhood trauma can lead to negative outcomes for adults, including homelessness. The Adverse Childhood Experience (ACE) Study indicated that having multiple adverse experiences during childhood could lead to long-term issues such as unhealthy coping mechanisms, health problems, and impaired development of cognitive, emotional, and social skills (Felitti et al., 1998). Humboldt County had the highest prevalence of ACEs among all California counties, with 30.8% of the population having at least 4 adverse childhood experiences (Center for Youth Wellness, 2014). In comparison, the state average for adults experiencing four or more ACEs is 16.7% (Center for Youth Wellness, 2014). The implications of having four or more adverse childhood experiences is daunting. For instance, a person that has 4 or more ACEs is 39% less likely to be employed, 11.6 times as likely to experience sexual violence as an adult, 3 times as likely to engage in risky health behaviors, 2 times as likely to report poor mental health within the past month, and 1.6 times as likely to report poor physical health within the past month (Center for Youth Wellness, 2014).

**Homelessness and Trauma**

Interestingly, trauma has not been well defined in the past (Ungar & Perry, 2012). One definition that seems the most relevant states that, “Trauma refers to an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person’s resources for coping” (Hopper, Bassuk, & Olivet, 2010, p. 80). Jeff Duncan-Andrade noted that in the past, the definition of PTSD was restricted to adults, mostly veterans (Chapman University, 2011). Ungar and Perry (2012) note that “...trauma is not the event—it is the
individual's response to the event” (p. 126). Trauma is something that is experienced by the individual, rather than something happening outside the individual.

The connection between trauma and homelessness has been explored in great depth by Hopper et al. (2010), who noted that, “Homelessness is a traumatic experience” (p. 80). There is a vicious cycle at play between homelessness and trauma. When abuse is involved, the risk for homelessness increases. Hopper et al. (2010) found that mothers that were homeless for the first time were more likely to become homeless again if domestic violence was involved; they also found a link between trauma history and becoming homeless for women due to decreased support networks. Hopper et al. (2010) note how traumatic stress increases vulnerability to homelessness, and that the effects of trauma can make it more difficult to cope with the stressors in being homeless. Those that have been traumatized are more likely to become homeless, and those that are already homeless are likely to be re-victimized (Hopper et al., 2010). The authors go on to suggest that, “we will be unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness” (p. 81).

Many of the following citations in the remainder of the Introduction are from a comprehensive book entitled, “Supporting Families Experiencing Homelessness: Current Practices and Future Directions” (Haskett, Perlman, & Cowan, 2014). The book provides a recent compilation of several relevant sources regarding the issue of families that face the challenge of homelessness. The authors of the various chapters often conducted a
thorough literature review of previous works that corresponded to the subject matter of their chapter, and they presented a summary and synthesis of many years of research.

**The Effect of Homelessness and Trauma on Children**

Impacts of homelessness on children include exposure to violence, unsafe environments, and stress from instability (Guarino, 2014). Eighty-three percent of children under age 12 that have experienced homelessness have been exposed to one or more serious violent events, which can include interpersonal or community violence (Guarino, 2014). Housing instability can consist of multiple moves and schools within a given year, and an unsafe environment can cause severe stress (Guarino, 2014).

Developmentally, children are especially vulnerable to trauma, and those experiencing homelessness are exposed to a greater degree of trauma than others. Thirty percent of people in families experiencing homelessness are children 5 years or younger (Perlman et al., 2014). These children may face challenges with respect to their capacity to communicate, ability to relate to others, and the ability to regulate their emotions (Volk, 2014). They are also at risk for having insecure attachments (Volk, 2014; Perry, 2002). In addition, 90% of the brain is already formed by the age of 5 years old (Perry, 2009). During early stages of development, it is the lower brain that is most affected by trauma (Perry, 2009). Later in life, the cognitive part of the brain (i.e., cortex) can be used to help self-regulate, but in a child affected by trauma early in life, this may not be possible (Perry, 2009). Consequently, if a child experiences homelessness and is affected
by trauma within her first five years, key developmental processes of the brain will be affected.

With respect to the effects of homelessness specifically on development, Volk (2014) found that children are most impacted during infancy and toddlerhood (13 to 36 months). In a literature review, Volk (2014) summarized that 4 to 6 year old children who had experienced homelessness during infancy and toddlerhood were impacted by reduced social skill development, decreased problem-solving ability, and chronic health problems. Children that experienced homelessness as toddlers are also likely to experience developmental delays and have difficulties with self-regulation (Volk, 2014).

For children six years and older that experience homelessness, traumatic events tend to happen in three key domains: 1) relationships with caregivers; 2) community and interpersonal violence; and 3) challenges at school (Cowan, 2014). These children may experience stressors related to homelessness that include disconnection from family and peers, changes in the role of their relationship with the parent, adjustment to shelter rules, and concerns with school (Cowan, 2014). Mental health outcomes are also affected, with 40% of children 6 to 18 years old showing aggressive behaviors (Cowan, 2014), and 43% exhibiting PTSD symptoms (Cowan, 2014). Family violence also affects children’s behavioral problems and their relationships with peers (Cowan, 2014). In addition, children who experience homelessness are more likely to be homeless as an adult (Cowan, 2014).
Trauma-Informed Care

Adults and children can experience many different post-trauma responses within the context of a homeless service setting (Guarino, 2014). They may be triggered by common stressors within the environment and can have a heightened state of arousal. Their survival responses may be perceived negatively by staff as oppositional or defiant for children or rude and aggressive for adults (Guarino, 2014). These effects can result in difficulty in building trust and relationships between clients and staff. It is not uncommon for adults to feel controlled, disrespected, or victimized by the structure of the setting; they may avoid services altogether within a homeless service setting (Guarino, 2014). These challenges can make it difficult for parents to want to access services for their children.

Trauma-informed care (TIC) is absolutely critical to serving families within transitional homeless settings. Guarino (2014) states, “Given the high rates of exposure to traumatic stress among families who are homeless, a trauma-informed approach is an essential component of quality care” (p. 122). Many regional and national initiatives support the use of TIC, through the development of programs such as the Homeless Resource Center (HRC), National Center for Trauma-Informed Care, and National Child Traumatic Stress Network (NCTSN) (Hopper et al., 2010). Instead of blaming or re-traumatizing, trauma-informed care seeks to understand and respond to the unique challenges of those experiencing trauma (Perlman et al., 2014). Hopper et al. (2010) presented a consensus-based definition of TIC that states:
Trauma-informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (p. 82).

Hopper et al. (2010) note how there needs to be a paradigm shift in homeless service settings “recognizing the central role of trauma in the lives of consumers” (p. 92). In addition, TIC is desired by consumers, and leads to better outcomes in terms of decreased psychiatric symptoms, substance use, greater housing stability, decreased use of crisis services, and positive organizational change (Hopper et al., 2010; Guarino, 2014).

**Resiliency**

Resiliency has been defined as an individual's capacity to figure out how to obtain the resources that they need, and to negotiate for having these needs met in the ways that they find most helpful (Ungar & Perry, 2012). Achieving resiliency requires an abundance of support from within a person's environment; Ungar and Perry (2012) note that resiliency “can only be achieved when the individual's social and physical ecology – their environment provides the relationships and opportunities required to succeed” (p. 130). Protective factors promoting resiliency include the strength of their relationship with their parent or caregiver, and the quality of the caregiving (Cowan, 2014). Volk (2014) states:
But, not all children experiencing risks evidence adverse outcomes—many evidence resilience….In other words, we must nurture children’s ordinary systems—their physical, cognitive, and social-emotional well-being. Strong attachment relationships, well-developed self-regulation skills, the presence of supportive adults, and opportunities to exercise their problem-solving skills are just a few of the ways we can support children. (p. 31).

In particular, interventions that focus on providing parental support focused on interactions between parent and child can be really helpful in breaking the multi-generational dynamic of unhealthy attachment behavior (Cowan, 2014). Perlman et al. (2014) also note the importance of the parent-child relationship as a protective factor.

Since relationships are a key protective process in dealing with trauma, opportunities for building meaningful relationships are extremely important to a child's resiliency. Protective processes can be viewed from several different levels, i.e., individual, family, and community (Olsson et al., 2003). Individual qualities which may be inherent or developed through experience, involve problem-solving and communication skills, a societally valued hobby or talent, and self-belief (Werner, 1995). At the family level, resilient children tend to have a stable and close relationship with at least one stable, caring adult. Several studies note the relationship with a caring adult as a critical protective factor (e.g., Ungar and Perry, 2012, Olsson et al., 2003, and Werner, 1995). The relationship is often with a caregiver, whether it is a parent or a substitute caregiver from the extended family (Werner, 1995). Within the community, however, this role can be played by several different people, including: peers, elders, or favorite
teachers (Werner, 1995). Werner also found that, for boys, resiliency is most enhanced in a household with structure and rules, as well as a strong male role model that also encourages the ability to express emotions; for girls, resiliency tends to come from homes that encourage independence and risk-taking with consistent emotional support from a female role model (Werner, 1995).

**Healing Interventions**

Key elements of promising practices in trauma-informed care include models that use psycho-education, social skill building, parent education, relationship-building, trauma education, positive parenting techniques, self-care, emotional intelligence, and a theoretical base (Hopper et al., 2010). Perlman et al. (2014) suggest the importance of providing interventions that can nurture relationships, promote secure attachments, avoid further stigmatization, find strengths, enhance capacity, provide an accepting environment, and build meaningful and trusting relationships. Cowan’s (2014) recommendations for addressing these effects on children’s mental health included providing interventions within the settings where families live; providing interventions that address trauma exposures, family violence, and other stressors; and sharing information about best practices cost-free among providers.

Interventions may also be more effective if they provide parents with greater awareness of the connection between their own childhood experiences and their parenting, including their own attachment history (Perlman et al., 2014). The authors describe this process as “parenting the parents as they parent their children” (Perlman et
They believe that such an approach helps the parents to reflect on their own past experiences and learn how to overcome inaccurate beliefs that may interfere with their ability to be nurturing to their own children. For instance, if a parent is preoccupied with their own past memories, they may be overwhelmed by emotions when their child behaves a particular way; they may lose their ability to respond in a sensitive and nurturing way in that moment (Perlman et al., 2014). Parenting interventions that help parents to become more available and responsive have been linked to improvements in parenting behaviors (Perlman et al., 2014).

**Project Context**

The Redwood Community Action Agency’s Multiple Assistance Center (RCAA/MAC) is a transitional living facility for homeless families. The project involved the development of a curriculum at the MAC regarding trauma education to help parents better understand the effects of trauma on their children and to be better able to help their children cope with and heal from the effects of trauma. This project falls within the scope of the TIC practice suggestions offered by Hopper et al. (2010) and Guarino (2014), which include trauma-specific services and interventions, and consumer involvement in the development of such services. The curriculum is expected to be implemented with the parents as a legacy to the project.

Development of a trauma-informed curriculum is important for these clients, because trauma is particularly prevalent in their history. Jeannie Campbell, LMFT, former head of clinical services at the MAC, noted that every assessment she has done for
a client at the MAC has indicated some impact from trauma in their personal history (J. Campbell, personal communication, October 30, 2014). In addition, the prevalence of trauma in the history of homeless families is well-established based on relevant research, as noted above. However, there is little information available regarding specific interventions that have successfully ameliorated the impacts of trauma on the children of homeless families within a residential setting.

The purpose of the project is to address the need for developing an effective research-based curriculum that could empower homeless families to heal from the effects of trauma. This purpose is consistent with RCAA’s long-term goal, "to develop programs through which people can become more self-sufficient and empowered to improve their own lives” (RCAA, n.d.). The curriculum was based largely on recent research by Dr. Bruce Perry, Peter Levine, Daniel Levine, and others in the field of childhood trauma. The goals of the curriculum are to provide parents with greater understanding of the effects of trauma, greater hope, and tools to help children heal from the effects of trauma. Topics included psycho-education about the effects of trauma on the developing brain and behavior, hope and resilience, warning signs, protective factors, importance of the parental/caregiver relationship, attachment, self-regulation, helping children process difficult emotions (emotion coaching, emotional first aid), positive discipline, and specific activities to help re-orient the brain. It is expected that the curriculum will directly address the recommendation by Hopper et al. (2010) for “[u]tilization of a theory-based model or framework [that] would help to ensure consistency across sites and help to begin to build evidence-based practices” (p. 93).
Theoretical framework

A trauma-informed and a strength-based perspective shape the curriculum for this project. The connection between a trauma-informed perspective and a strength-based approach can perhaps best be summarized with the following quote from Perlman et al. (2014):

A commitment is made to facilitate recovery by creating a strength-based, empowering, predictable environment that allows people to rebuild personal control and efficacy over their lives. Rules and protocols are rewritten with more realistic expectations to encourage self-reflection, personal responsibility, and community buy-in. Mutual trust, respect, and collaboration are enhanced as staff and consumers together are taught about the effects of trauma and learn new coping and self-care skills (National Center on Family Homelessness, 2009). (p. 67)

The emphasis on efficacy and control cannot be underestimated. The mutual respect and trust among clients and staff can be a result of learning about trauma together. Volk (2014) states, “Given the prevalence of traumatic experiences in the lives of homeless children and families, adopting trauma-informed perspective is essential to working with them.” (p. 33). In addition, Perlman et al. (2014) found preliminary research to indicate that transitional or emergency housing settings that incorporated a trauma-informed lens tended to produce better outcomes than those that did not.
In a strength-based approach, individuals are held with dignity and respect and are recognized for their expertise (Robbins et al., 2006). The strengths perspective recognizes that individuals and groups can gain control of their lives through the use of resources and capacities that they already have (Robbins et al., 2006). This approach is relevant to the way that we view the effects of trauma on families and is consistent with a trauma-informed lens. We believe that families can recover, and that they have the expertise to understand their own family in a way that will help them to be their child’s best asset.

The strength-based approach has also recently gained momentum in terms of family strengthening and support. For instance, the California Network of Family Strengthening Networks (CNFSN), of which Humboldt County is a part, recently developed standards that operationalize the combination of a family support network with a family-strengthening protective factors framework (CNFSN, 2014). The family support network assumes that the family is primarily responsible for the development of its children, and that it is the responsibility of all of society to support families in the raising of their children (CNFSN, 2014). It requires that staff and families work together in respectful and equal relationships, and that staff help enhance the capacity of families to support development and growth of their members; the families are considered resources to other families and to the community (CNFSN, 2014). The family strengthening protective factors approach is guided by the ideas that every family has strengths, and that every family also needs support (CNFSN, 2014). This framework includes the concepts of social connections, knowledge about child development, parental resilience,
children’s emotional and social competence, and concrete support for families (CNFSN, 2014).

Strengthening at-risk and homeless families requires creating solid foundations through early intervention services, supporting caregivers, and connecting these vulnerable families to programs that focus on families in the community (Volk, 2014). Perlman et al. (2014) note the importance of building strength and capacity when helping support parents that are homeless in their parenting practices. As mentioned earlier, Hopper et al. (2010) include strength-based within their definition of trauma-informed care. They go further in stating that skill-building is an important aspect of increasing resiliency within a TIC service setting. In addition to being strength-based, a trauma-informed approach emphasizes awareness and understanding of trauma at many different levels, including all levels of staff (Hopper et al., 2010). A trauma-informed approach emphasizes emotional and physical safety as well as opportunities for consumers to have input and control over the services that they are being provided (Hopper et al., 2010).
Method

Overview

The purpose of the project is to address the need of developing effective research-based curriculum that will help empower homeless families in their efforts to heal from the effects of trauma experienced at RCAA’s the MAC. This section is organized to describe the population served, information and materials needed to create the curriculum, project overview, project methods, and relational accountability. Lastly, ethical considerations, limitations of the project, and a summary conclude this section.

Population Served

The population served by this project consists of up to 22 homeless families, primarily with young children, temporarily residing at the MAC in Eureka, California. The MAC program provides transitional housing and wrap-around services (i.e., case management, mental health services, living skills training, provision of daily meals) for homeless families that are Humboldt County residents, with the goal of reaching self-sufficiency and finding permanent housing. The MAC is transitioning to serve single homeless adults in the summer of 2015. It had been the practice of the MAC that the majority (90%) of families were required to participate in DHHS Social Services Division CalWORKs/Welfare-to-Work Program; 10% of families that were accepted into the MAC were not eligible to participate in that program. The curriculum may also
benefit those who are not currently living at the MAC, single parents that live at the MAC after the transition to singles occurs in June of 2015, and also homeless families living at RCAA’s two other transitional living locations.

The staff who are intended to use the curriculum are mental health clinicians, family services staff, and case managers who are interested in educating clients about the effects of trauma, and in the ways that parents may help their children to cope better with trauma. During the course of the project, staff members from each of these positions expressed interest in learning about and potentially using elements of the curriculum in their direct service work with clients. Several staff expressed interest in presenting the curriculum at RCAA’s other sites where families will continue to reside after the MAC itself transitions to singles.

**Overview of Information and Materials Needed**

This section describes the information and materials used to develop the project. The project is a curriculum designed to help educate parents about the effects of trauma and practical parenting skills related to helping children to heal from these effects.

The curriculum was informed by the interview process, scholarly literature, my clinical experience working with people, and experts in the field. The interview process directly informed what was to be the focus for the content based on desired outcomes identified by interviewees; see Discussion for greater detail on how the interview results informed the curriculum. My previous experience as an intern at the HSU Community Counseling Clinic, working with families whose children experienced trauma, also
informed my selection of materials for the curriculum. The integration of materials from the scholarly literature and experts in the field is described below.

I included scholarly materials such as those from Dr. Bruce Perry in the curriculum. I explored many concepts from Bruce Perry (Perry, 20002, 2006, Ungar & Perry, 2012) in the initial sessions to provide psychoeducation regarding the effects of trauma and the hope and methods that are effective with working with healing from these effects. Throughout the following weeks, I also referenced these materials as a way to re-enforce knowledge and understanding. I also included excerpts from Theraplay methods described by Jernberg & Booth (1999) and Munns (2009) for activities that could be useful for parents to try with their children.

The curriculum included relevant materials created by experts in the fields of trauma and parenting, such as Bruce Perry, Peter Levine, Pnina Klein, Gabor Mate, Regelena Melrose, Daniel Siegel, Jane Nelsen, and The National Child Traumatic Stress Network (NCTSN). For instance, I included several video links to Bruce Perry interviews that explain in easily understandable language the effects of trauma on the brain. The curriculum contains reading and writing exercises using a study guide (ChildTrauma Academy, 2014) that applies to Perry and Szalavitz’s (2008) “The Boy who was Raised as a Dog”. Many of the activities presented regarding emotion coaching in Week 9 are based on materials from Levine (2004), which is designed to help parents or caregivers to help their children process emotions directly after a traumatic event. I also provided links to websites that reference experts in the fields of trauma such as NCTSN (n.d.), and parenting, such as Kids in the House (2015).
Project Overview

This project process was represented in Figure 1. The process began with clients and staff being interviewed. The interview results, experts, scholarly literature, and my clinical experience were then used to inform the initial curriculum draft. The curriculum draft was sent for staff review, which informed the final version of the curriculum.

Figure 1. Conceptual flow diagram of the process and activities used to create a trauma education curriculum for the MAC.
Project Methods, Relational Accountability

Data were gathered from three participants and seven staff during the interview process, and comments were gathered from one staff during the review process. I was relationally accountable to the community by leaving the project’s culminating results (group curriculum) as a resource for future use in group or individual settings, and also by incorporating client feedback into the development of the curriculum. Although there were fewer client interviews than staff interviews, the weight carried by client interviews was equal to that of staff when designing the actual curriculum. The overall process also allowed feedback from MAC staff to be incorporated after the initial draft review of the curriculum.

Interviewees were selected for interviews via convenience sampling. Potential interviewees were identified by sending email messages to interested staff, and by personally communicating with clients about the project. Interviews were conducted based on a topic guide (see Appendix A), and were from 15 to 20 minutes long. The benefit of using a topic guide is that the interviewee can steer the conversation in a direction that can provide useful information that may not be obtained through a more structured interview process. Interviews were conducted with staff and client participants at the MAC. Information was recorded by hand during the interview, and later transcribed to electronic format.

Analysis of interview results employed an emergent method, where the next steps were guided by my initial review of the data. The results were reviewed twice, the first
time noting major patterns that were emerging overall. I wrote down answers from each client as shorter descriptors, and noted which interviewees were associated with which answers. These initial responses were then reviewed per each topic area to discern patterns, which were written about in greater detail. I looked for overall patterns at first, irrespective of whether the answers were coming from staff or clients, although I noted any substantial differences in the answers between staff and clients.

These initial results were later reviewed to identify major themes that would influence development of the curriculum. Themes were identified if they were repeated by multiple interviewees, or if they resonated with ideas in the researched literature. I attempted to identify specific themes per topic area, and looked more specifically at how the themes differed between clients and staff. I created tables summarizing themes per topic area, and recorded the number of clients and staff associated with each theme. During this process, I also identified key quotes. I validated my perceptions based on a re-check of how many interviewees were associated with given themes.

I designed the curriculum to be 12 weeks to adequately cover the areas of psychoeducation about the effects of trauma, the healing process, and specific tools for parents in helping their children to heal. I covered the topics of psychoeducation about the effects of trauma on the developing brain and behavior, hope and resilience, warning signs, protective factors, importance of the parental/caregiver relationship, attachment, self-regulation, helping children process difficult emotions, positive discipline, and specific activities to help re-orient the brain. I developed topics for each week based on the input from the interviews regarding desired outcomes as well as specially identified
topics from the interviews. Due to the interest in technical knowledge expressed by clients, I also included information from the field of neuroscience as related to trauma. Please refer to the Discussion for greater detail on how specific themes identified during interviews informed different aspects of the curriculum.

For each week, I used a format which included the elements: desired outcome, notes to facilitator, day at a glance, detailed activity plan, closure, next week’s topic, and optional activities. The desired outcome stated the specific outcome that the week’s curriculum was designed to meet. Notes to facilitator were added to flag important issues or optional activities that I thought might be valuable. Day at a glance provided a brief overview of the materials for the day, and the detailed activity plan provided instructions on facilitating specific aspects of the curriculum. Closure and next week’s topic provided participants with an opportunity for brief discussion about what was learned and preparation for the following week’s topic. Finally, optional activities provided many alternate plans for facilitators to consider, depending on the desires and composition of their group.

After the initial draft curriculum was created, feedback was collected from one staff regarding the content and organization of the curriculum. Staff was provided with an electronic version of the curriculum and was asked to provide comments on how the curriculum could be improved. Comments and edits from the staff review were then incorporated into the final version of the curriculum.
Ethical Considerations

One ethical consideration is working with a vulnerable population. Creation of the curriculum through the interview process did not however pose a threat to that vulnerability. The interview questions were not of a personal nature, and did not cause any re-traumatization for the clients. The interview and review processes were determined to be exempt by the Institutional Review Board (IRB), IRB #14-103.

I asked for consent to interview clients and staff to help build the curriculum, and also during the curriculum draft review process. Please refer to Appendix B for consent forms. Informed consent will be kept for 3 years in a locked file cabinet, within a locked room for three years. The consent forms will be physically destroyed after 3 years.

There were no direct benefits, and there were no potential risks. The indirect benefit would be for the adults to know that they are contributing to a curriculum that may benefit others.

For the purposes of this project, I knew the identity of the participants, but nobody else did. The data made publicly available via this report are included in a summarized format without any identifying information.

Data from the interviews were maintained until the project was completed. Data were recorded via written notes during interviews and stored in a locked cabinet within a locked room. The data were then transcribed into a computer, at which point the written form was destroyed. After the project was completed, the electronic data were deleted from the computer storage.
Limitations of the Project

The limitations of the project are that the interviewees may not have been fully representative of the population at the MAC, the curriculum design itself is limited by what it can actually address, and that group dynamics affect implementation. Another limitation is that the original vision for implementation of the project may not be possible, given the changing circumstances regarding use of the MAC in the near future. This study was not designed to be generalizable, as that was never really the goal of the project. Its primary objective was to be effective for use with the population of study, families, at the MAC; therefore, the limitations of a qualitative study in this sense are not really applicable.

Representativeness of the sample may have been influenced by several factors. For instance, those that participated in the survey were likely to be more interested in the subject matter of trauma education than others that did not want to participate in the interview. The interviewees may have been more aware of the issues related to trauma than some of their peers. In addition, I met with 3 clients, so representativeness is limited by the small number of client interviews. Unfortunately, turnover of staff and clients as well as organizational changes complicated the rapport-building process, which may have also hindered attempts to get more interviews. Furthermore, factors beyond our control made it difficult for us to really know if the type of participants that contributed to our survey would be representative of those in the future, due to the transition at the MAC from families to singles. The limitation of representativeness was considered when
designing the curriculum. For instance, I decided to include elements that would still be useful for those that were less interested in the technical details, even though interviewed clients expressed interest in a high level of technical knowledge.

The curriculum itself is limited by what it can address, as it has a narrowed focus on trauma and parenting. Although it would be valuable to specifically address trauma in the parents’ experience for instance, this was not the focus of the project. The focus of the curriculum was ultimately defined by existing participants, making it relevant and representative to the extent possible with a specific population of interest at the MAC.

Another limitation is that group dynamics and the way that the group is facilitated, will play a large role in how the curriculum is implemented. This consideration was addressed by forming relationships with those staff who are likely to use the curriculum in the future. These staff members are aware of the value of trauma-informed care, and they had expressed a desire to implement the curriculum in a respectful way.

The final limitation is that the MAC may no longer house families, so that implementation of the project cannot really happen in the way it was originally envisioned. It can, however, be used by staff at RCAA’s other transitional living locations and by others that are working with families affected by trauma. It may also be useful for single parents who will be residing at the MAC after the transition. This limitation was addressed, in part, by making each week of the curriculum functional as a stand-alone curriculum.
Summary

In summary, the purpose of the curriculum was to serve the homeless population at the MAC, primarily families and possibly eventually single parents, in a trauma-informed way. The information and materials used to develop the curriculum were the interview results, expert knowledge, scholarly materials, and my professional experience. I incorporated MAC input before and after curriculum development through an interview process and a review process, respectively. Project methods were relationally accountable through these processes and included curriculum development that included the areas of psycho-education about the effects of trauma, the healing process, and specific tools for parents in helping their children to heal. Each week of the curriculum was designed to include specific ideas and suggestions for facilitators in addition to optional activities. An ethical consideration was that the population is vulnerable, so steps were taken to ensure confidentiality and provide safety. Limitations of the project included limited representativeness of the sample, narrowed focus of the curriculum, and implementation challenges.
Results

This section contains results of interviews with staff and clients, organized by topic area. The final version of the curriculum can be found in Appendix C. Please refer to the Appendix C for details on each of the 12 weeks.

Definition of Trauma

Table 1 summarizes many of the themes related to how clients and staff define trauma, while Table 2 identifies key quotes indicative of certain themes. Six of 10 interviewees related trauma to an event rather than the person’s experience of an event as seen in Table 1. Interestingly, people that did relate trauma to a person’s experience tended to relate it also to an event, as in, “An event or experience of an event that exceeds an individual’s capacity”. One client also related to trauma as an event or an experience. Sixty percent of interviewees noted that trauma has a negative effect on individuals. One client did not relate the effects as either positive or negative, simply, “that leaves a mental or physical imprint on your life.” (Table 2). This response may reflect a non-judgmental attitude and resilience. Of the six interviewees that identified negative effects, one third noted that the effects were longer lasting.

Table 1. Themes expressed regarding the characterization of trauma and approaches to making it easier to discuss the topic of trauma in a support group setting.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
<th>Staff</th>
<th>Clients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you characterize</td>
<td>Event</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Question trauma?</td>
<td>Theme(s)</td>
<td>Staff</td>
<td>Clients</td>
<td>Total</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
<td>-------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>Experience</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Negative effect</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Link with abuse, PTSD, or unhealthy relationships</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>What would make it easier to discuss the topic of trauma?</td>
<td>Safe, non-judgmental environment</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Letting people know it was ok</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Common bond of the trauma experience</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Facilitator maintaining safety</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Concern about being triggered</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Important to establish safety guidelines</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 2. Illustrative quotes as related to themes and interview questions regarding the characterization of trauma and approaches to making it easier to discuss trauma in a support group setting.

<table>
<thead>
<tr>
<th>Question How would you characterize trauma?</th>
<th>Theme(s)</th>
<th>Key Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you characterize trauma?</td>
<td>Event, experience</td>
<td>“An event or experience of an event that leaves a mental or physical imprint on your life”</td>
<td>Client</td>
</tr>
<tr>
<td></td>
<td>Link with abuse, PTSD, or unhealthy relationships</td>
<td>“Trauma occurs when one person is taking the abuse, when the other person should be giving something else.” “[Trauma] impedes people’s progress to have healthy relationships.”</td>
<td>Client</td>
</tr>
</tbody>
</table>

| What would make it easier to discuss the topic of | Letting people know it’s ok | “Letting them know that just because they suffer from trauma they haven’t lost anything.” | Client |
Difficulty having healthy relationships was one of the consequences linked to trauma, when interviewees were asked to define trauma (Table 1). Other interesting connections included the link between trauma and PTSD and abuse (Table 1). The relationship to abuse was particularly striking and indicated an element of betrayal. One client noted how, “Trauma occurs when one person is taking the abuse, when the other person should be giving something else.” Another interviewee, perhaps reflecting on her own personal experience, noted how trauma “impedes people’s progress to have healthy relationships.”

In answering the question, “What would make it easier to discuss the topic of trauma?” clients and staff both noted the importance of a safe, non-judgmental atmosphere. Clients specifically noted the importance of letting people know that it was okay that their family had experienced trauma, and that they were not damaged. One client also noted how she would feel less judged if she knew that the facilitator had also experienced trauma. Staff noted the importance of the common bond of having experienced trauma. Staff also noted concern about participants being triggered and the importance of establishing safety and confidentiality guidelines to protect clients.
**Understanding Effects of Trauma on the Brain**

Table 3 explores interview responses about the effects of trauma on the brain, and Table 4 includes key quotes indicative of certain themes. Six of 10 interviewees noted that trauma negatively affects the brain and 4 of 10 interviewees noted that trauma negatively affects behavior (Table 3). One staff member and one client noted the link between traumatic effects on the brain and addiction. One client noted problems with attachment and connecting with others; this client eloquently stated:

> If a child is always anxious and not nurtured or secure, when becoming an adult, they will feel different than everyone else, and process things differently. If a child never got that bond, there would be problems connecting with others and with relationships.

In a similar vein, one staff member noted how people can sometimes “get stuck at the age of trauma”.

Table 3. Themes found regarding the topic area of understanding effects of trauma on the brain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
<th>Staff</th>
<th>Clients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you know about trauma?</td>
<td>Negatively affects the brain</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Negatively affects behavior</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Link between trauma and addiction</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Importance of child’s developmental stage</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fight or flight response</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Acting out or self-destructive behavior</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Negatively affects relationships/attachment</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>What level of</td>
<td>1 (Least technical)</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Question</td>
<td>Theme</td>
<td>Staff</td>
<td>Clients</td>
<td>Total</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
<td>-------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>background information on trauma is useful or interesting to you?</td>
<td>1-3</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2-3</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3-4</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5 (Most technical)</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 4. Themes expressed about understanding the effects of trauma on the brain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme(s)</th>
<th>Key Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you characterize trauma?</td>
<td>Negatively affects the brain, Fight or flight response, Acting out or self-destructive behavior. Negatively affects relationships/attachment.</td>
<td>“Any trauma, from neglect to emotional/physical impact, changes the entire make-up of a child’s brain.” “Trauma in the moment stimulates the limbic system, overwhelms the pre-frontal cortex, causing the person to go into survival mode and be more emotional.” “If a child is always anxious and not nurtured or secure, when becoming an adult, they will feel different than everyone else, and process things differently. If a child never got that bond, there would be problems connecting with others and with relationships.”</td>
<td>Client</td>
</tr>
<tr>
<td>Technical knowledge</td>
<td>1-3</td>
<td>“There are lots of different educational levels, but staying at 1-2, up to 3, might cover most people. You can present more technical information, but it might be good to pair it with less technical information so you don’t lose folks.”</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>2-3</td>
<td>“Explaining that trauma is common to all people normalizes the experience and is healing.”</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>“Education helps to see things a lot differently. It can make it easier to feel</td>
<td>Client</td>
</tr>
</tbody>
</table>
Two staff members mentioned the importance of a child’s developmental stage in how the trauma affects the brain. If trauma occurs earlier in a child’s development, the effects of trauma on the brain tend to be much greater. These interviewees also noted how the brain can be overwhelmed by the trauma and that the response tends to be fight or flight. Two others noted how later as an adult these effects can result in “acting out behavior” and self-destructive behavior in particular. As one staff member insightfully noted, “Trauma in the moment stimulates the limbic system, overwhelms the pre-frontal cortex, causing the person to go into survival mode and be more emotional”.

In terms of the degree of technical knowledge, it is interesting to note that the clients interviewed want a higher level of technical knowledge (mean of 4.7, range of 4 to 5, scale of 1 to 5) than what the staff thinks will be most useful to the client (mean of 2.6, range of 1 to 4) (See Table 4). One client stated that she needed more information to be convinced due to her “inherent skepticism”, and the other two noted that they valued research and education. The skepticism was related to that particular client’s desire to have everything proven to her, before she could believe it. In contrast, staff believed that the technical information should be simplified due to clients having varying educational backgrounds, and others noted that people might lose interest quickly if the information was too technical. Staff and clients did agree that education was important overall; some
of the responses (2 staff, 1 client) noted that education is normalizing and removes blame. The issue of blame appeared to be a recurring theme throughout the interview answers. Staff sometimes indicated sensitivity about the clients feeling blamed for their children’s behavior, and clients also indicated a desire not to be blamed.

**Practical Tips**

Table 5 characterizes interview responses related to practical tips, and Table 6 identifies key quotes indicative of certain themes. In discussing the question of whether they were more interested in how their child was affected or what the patterns of behavior are, all three clients stated that how the child experiences trauma and what the trauma-affected behavior looks like were equally important. In contrast, four of seven staff members thought that the class should focus more on patterns of behavior. Some interviewees noted that understanding how a child was affected by trauma was important for increasing empathy and/or normalizing the experience (2 staff), and that what the behavior looks like has practical significance (4 staff, 1 client) in aiding parents to look for help.

Table 5. Themes expressed regarding the topic area of practical tips.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
<th>Staff</th>
<th>Clients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you more interested in how your child is affected or in the patterns of behavior?</td>
<td>How child experiences trauma and what behavior looks like equally important</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>What behavior looks like is more important</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Importance of parents addressing own trauma</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Although not directly related to the question, it was interesting to note that two of the three clients expressed how important self-care was in terms of how they parented their children (Table 5). One client in particular noted that it was difficult to provide proper care for her child when she was feeling overly stressed. She tied the idea of healing from trauma with the idea of self-care, stating:

It is important for the parent to get help for their trauma. If they are overly focused on their children, they won’t be able to care for themselves. You don’t want to forget about yourself and your own mental health and needs.

Table 6. Key quotes from the topic area of practical tips.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme(s)</th>
<th>Key Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you more interested in how your child is affected or in the patterns of behavior?</td>
<td>Importance of parents addressing own trauma, importance of self-care.</td>
<td>“It is important for the parent to get help for their trauma. If they are overly focused on their children, they won’t be able to care for themselves. You don’t want to forget about yourself and your own mental health and needs.”</td>
<td>Client</td>
</tr>
<tr>
<td>Are you open to suggestions?</td>
<td>Style of delivery critical, Blame</td>
<td>“I find it better when other parents make the suggestion rather than staff.”</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“This isn’t your fault; these things happen.”</td>
<td>Client</td>
</tr>
<tr>
<td>Question</td>
<td>Theme(s)</td>
<td>Key Quote</td>
<td>Source</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Multi-generational nature of trauma.</td>
<td>“It’s important to let parents know that they’re not doing a bad job, but that they could use more information or support; working on their strengths, and bringing them out.” “Trauma is multi-generational. A parent may not have dealt with their own trauma, so it would be harder to address taking action on those tips. Education is important for recognizing multi-generational effects of drug addiction and violence. The class might spur parents to enter counseling for themselves to help integrate tips for their children. The default is the generational pattern.”</td>
<td>Staff</td>
</tr>
</tbody>
</table>

In asking about whether participants would be open to suggestions, seven of 10 interviewees said yes, including all three clients (Table 5). Three staff members stated that at least some parents would be in denial that their child was affected by trauma. In addition, of the seven yes responses, four staff members qualified their affirmative response by stating that the style of delivery was critical to parents receiving these tips well. Three staff members thought that some parents would not realize that their children had been affected by trauma. They mentioned the importance of emphasizing that it’s not the parents’ fault or that it was important to recognize the parent’s expertise, having interactive activities, practicing skills, normalizing the trauma experience (i.e., it’s not your fault, relating with others), emphasizing strengths, and explaining that the trauma was multi-generational.

In contrast, none of the clients qualified their answer of “yes”. One client noted that everyone needs more coping skills. Another client noted that it was critical to let
parents know that it wasn’t their fault. The latter statement fits the theme for which staff members (4) contributed heavily: that the style of delivery is critical to clients being receptive to the suggestions. Interestingly, one staff member noted how, “I find it better when other parents make the suggestion rather than staff.” One client noted the recurring idea of blame, stating that she thought parents might need to hear, “This isn’t your fault; these things happen.”

One staff member had the insight that, although many parents would be open to the tips, they might have great difficulty fully integrating the tips into their parenting due to the multi-generational aspect of trauma. This person duly noted the power of the multi-generational nature of trauma:

Trauma is multi-generational. A parent may not have dealt with their own trauma, so it would be harder to address taking action on those tips. Education is important for recognizing multi-generational effects of drug addiction and violence. The class might spur parents to enter counseling for themselves to help integrate tips for their children. The default is the generational pattern.

**Practical Suggestions for Re-Orienting the Brain**

Table 7 explored themes regarding the topic area of practical suggestions for re-orienting the brain, and Table 8 identified key quotes related to this topic area. The idea of blame re-emerges in this topic area, even though it is not directly asked (Table 8). It appears that there is great sensitivity to the potential for blame, a theme that is supported by the literature. Four out of seven staff members expressed the belief that learning about
what activities to try (the how) was more important than understanding why. On the other hand, two thirds of the clients thought that the how and why were equally important. The implication is that clients want more information about the why than staff believe is necessary for the curriculum. Some staff reasoned that if the reasons why had already been established in earlier sessions it would not be necessary to explain why with respect to activities. One staff member noted how she thought, “Some background information is ok, but not as much. Our population learns more through doing.” One client was in agreement with this idea, stating, “I’m less interested in why, but more interested in what I can do. I would want to build my toolbox to help him [her child] later in life.”

Table 7. Themes expressed regarding the topic area of practical suggestions for re-orienting the brain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
<th>Staff</th>
<th>Clients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you more interested in understanding why or how to do activities related to re-orienting the brain?</td>
<td>How and why equally important</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>How more important than why</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Understanding why helps with follow-through</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 8. Key quotes from the topic area of practical suggestions for re-orienting the brain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme(s)</th>
<th>Key Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you more interested in understanding why or how to do activities</td>
<td>How more important</td>
<td>“Some background information is ok, but not as much. Our population learns more through doing.”</td>
<td>Staff</td>
</tr>
<tr>
<td>Question related to re-orienting the brain?</td>
<td>Theme(s)</td>
<td>Key Quote</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understanding why helps with follow-through, Blame</td>
<td>“I’m less interested in why, but more interested in what I can do. I would want to build my tool box to help him [her child] later in life.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understanding why helps with follow-through, Blame</td>
<td>“People are not as resistant if they know what’s behind the activities, and that you’re not just telling them to do something.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understanding why helps with follow-through, Blame</td>
<td>“Understanding why makes for a greater chance of follow-through.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understanding why helps with follow-through, Blame</td>
<td>“Some might just do it, but others might need to understand why. It would be based on their idea of what’s traumatizing or not, based on what was normal in their childhood. It must be done in a way that doesn’t place blame, making a child as well-adjusted as possible; people fear being blamed.”</td>
<td></td>
</tr>
</tbody>
</table>

Other staff thought that the activities may not be taken seriously, unless they were specifically connected to the reasons for doing them. For instance, one staff member noted that they felt that the reasons why could be more important than the reasons how due to the clients’ need to understand why before committing to action. One staff member insightfully noted:

Some might just do it, but others might need to understand why. It would be based on their idea of what’s traumatizing or not, based on what was normal in their childhood. It must be done in a way that doesn’t place blame, making a child as well-adjusted as possible; people fear being blamed.
Format of the Group

As seen in Table 9, there was a wide range of diversity in the types of names that interviewees described. Table 10 identified key themes related to the format of the group, and Table 11 contains quotes that are descriptive of particular themes. Many of the names suggested by interviewees did not include the word “trauma”. Most staff (6 of 7) and clients (2 of 3) noted that there could be some hesitation with attending a class with “trauma” in its title. Some (2 staff, 1 client) stated specifically that they personally would attend despite that hesitation. One client noted, “There may be some hesitancy, but I would attend…You have to face where you are before being able to go somewhere else.” Two staff members spoke strongly of the need to include the word “trauma” in either the title or class description so as not to be misleading, despite acknowledging hesitancy with attending such a class. Another staff member noted that, “Saying it like it is may not be a deterrent for some.” Six other staff members did not think the word “trauma” needed to be in the title. One mentioned that the offering of a 4-week class with certificate of completion (with opportunities to make up classes 1-on-1) might be good incentive to work through the hesitation that clients may experience.

Table 9. Potential names for the class provided by interviewees.

<table>
<thead>
<tr>
<th>Names for the class:</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Trauma-informed Parenting: Have your children been exposed to drug abuse, domestic violence, child abuse, or homelessness? If so, then your child may be affected by trauma.”</td>
<td>Staff</td>
</tr>
<tr>
<td>“New Growth Sprouting”</td>
<td>Staff</td>
</tr>
<tr>
<td>“Coming Forward from the Past into the Future”</td>
<td>Staff</td>
</tr>
<tr>
<td>“Trauma 101”</td>
<td>Client</td>
</tr>
<tr>
<td>“Foundation Building”</td>
<td>Client</td>
</tr>
</tbody>
</table>
Names for the class:

<table>
<thead>
<tr>
<th>Source</th>
<th>Class Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>“New Beginnings”</td>
</tr>
<tr>
<td>Client</td>
<td>“Happy Trails”</td>
</tr>
<tr>
<td>Client</td>
<td>“Coming out of Rough Waters”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Trauma Workshop”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Healing from Adverse Experiences”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Promoting Healing”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Learning Resilience in a Traumatic Environment”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Experiencing Hope after Trauma”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Seeking Healing”</td>
</tr>
<tr>
<td>Client</td>
<td>“Understanding Trauma”</td>
</tr>
<tr>
<td>Client</td>
<td>“Rebuilding, Retracing your Steps”</td>
</tr>
<tr>
<td>Client</td>
<td>“Adolescent Healing”</td>
</tr>
<tr>
<td>Client</td>
<td>“Helping your Child through Trauma”</td>
</tr>
<tr>
<td>Staff</td>
<td>“Emotional Wellness: Addressing Issues Related to Trauma”</td>
</tr>
</tbody>
</table>

Table 10. Themes found regarding the topic area of format for the group.

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
<th>Staff</th>
<th>Clients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you have some hesitancy attending a group with the word “trauma” in its title?</td>
<td>No hesitancy</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Yes, hesitation if trauma in title</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Would attend despite hesitation</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Word “trauma” needs to be in title, otherwise misleading</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Word “trauma” not needed in title</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>How do you like information presented?</td>
<td>Video</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Handouts</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Powerpoint presentations</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Read-write exercises</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Art, case-scenarios, role-playing (1 each)</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Personal vs. general discussion?</td>
<td>Personal only</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>General only</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>General and personal</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Felt strongly about the value of</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Question</td>
<td>Theme(s)</td>
<td>Key Quote</td>
<td>Source</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Would you have some hesitancy attending a group with the word “trauma” in its title?</td>
<td>Blame, Self-care</td>
<td>“They need more attachment-based parenting, more patience, strategies, and tools. The parents may need help with managing their own self-care. Children affected by trauma may have more tantrums. There is no guilt or shame, but parenting may be more difficult. The message to parents is that it’s not your fault.”</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>Hesitancy</td>
<td></td>
<td>“something that symbolizes uplifting, a new trail… It is a little scary, would have some hesitancy if trauma was in the title. It is a hard, abrasive word; need softer language, maybe ‘Coming out of Rough Waters.’ ”</td>
<td>Client</td>
<td></td>
</tr>
<tr>
<td>Hesitancy, but would attend</td>
<td></td>
<td>“There may be some hesitancy, but I would attend… You have to face where you are before being able to go somewhere else.”</td>
<td>Client</td>
<td></td>
</tr>
<tr>
<td>How do you like information presented?</td>
<td>Video, Discussion</td>
<td>“I received good feedback for mixing it up. I would play a video, then we would discuss the video. I would talk about why I showed the video and have some discussion about it.”</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
<td>“I am interested in talking specifically about personal experiences. You can get it out there quickly, and use other people’s tools, give advice, and receive advice.”</td>
<td>Client</td>
<td></td>
</tr>
<tr>
<td>Personal vs. general discussion?</td>
<td>Personal</td>
<td>“I think people take information best when it’s personal to them.”</td>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Research on trauma and homelessness suggests that specific is good.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I am interested in talking specifically about”</td>
<td>Client</td>
<td></td>
</tr>
</tbody>
</table>

Table 11. Key quotes from the topic area of format for the group.
<table>
<thead>
<tr>
<th>Question</th>
<th>Theme(s)</th>
<th>Key Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal, Avoid re-traumatization</td>
<td>Personal experiences. You can get it out there quickly, and use other people’s tools, give advice, and receive advice.”</td>
<td>“Talking personally would make it easier for clients to address their needs. It would be better to talk about personal stuff; it’s more applicable. It would also be important to watch for re-traumatization.”</td>
<td>Staff</td>
</tr>
<tr>
<td>General, Avoid re-traumatization</td>
<td>“I am not interested in talking about specifics of personal experience. I am more comfortable with general discussion. I don’t want to re-traumatize myself or others.”</td>
<td></td>
<td>Client</td>
</tr>
<tr>
<td>General and personal, Value of sharing personal stories</td>
<td>“I like the hope, different suggestions, and being able to connect. Some balance might be best. The group may go through different stages. The first few classes may be informational, and the last few classes could be more personal.”</td>
<td></td>
<td>Client</td>
</tr>
<tr>
<td>General and personal, Gender specific</td>
<td>“A little of both, but access to talk 1-on-1 with staff about personal experiences. Sharing would be more general in group, depending on size. Same sex groups would be safer for sharing greater personal detail.”</td>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>“It might need to be gender-specific. Women might be more honest with each other in a gender-specific group. People might be less likely to be open about trauma with mixed gender. More general discussion would be better if it is a mixed group.”</td>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td>Maintaining safety</td>
<td>“The group needs to be facilitated with clear guidelines about length and appropriate detail of the share. Could provide options for those talking more specifically and at length.”</td>
<td></td>
<td>Staff</td>
</tr>
</tbody>
</table>

All seven staff responses stated that video would be a preferred mode of information dissemination, although most client responses (2 of 3) highly valued discussion as a primary mode. Clients did however identify video, handouts, and writing exercises to also be valuable modes of presentation. One staff member noted the past
success of mixing up video with discussion and lecture, with the idea of introducing why the video was being played, showing the video for up to 10 to 15 minutes maximum, then discussing the video. Another staff member mentioned the idea of interspersing video with physical practice activities. Staff also identified discussion (4), hand-outs (3), PowerPoint slide presentations (3), read-write exercises (2), art (1), case scenarios (1), and role-playing activities (1) as possible ways to present the information. One staff member noted that classes should involve “less talking at clients, and more engagement.”

On no other question were people, both staff and clients, so vehemently divided than the question asking if clients would prefer personal versus general discussion. Interviewees felt strongly one way or the other. Those wanting general discussion only (2 staff, 1 client) were concerned with re-traumatization and preferred the idea of using 1-on-1 counseling outside of the group to talk more specifically about their experiences. One client had no interest in personal discussion whatsoever. The two staff members who wanted general discussion qualified their answer to say that personal discussion was a possibility if everyone agreed that they wanted personal discussion, with one of the two noting that there needed to be informed consent and the other noting that a smaller, gender-specific group would be needed for safety. Some of those same concerns were also identified by those voting for “both” (4 staff, 1 client). For instance, one of the four staff members noted that a gender-specific group might be needed if personal information was to be shared. Three of the five interviewees noted how the group could start with more general discussion, and as people began to trust each other more, the discussion could become more personal in later sessions. Overall, whether interviewees were
interested in personal discussion, general discussion, or both, five interviewees noted the importance of maintaining safety and avoiding re-traumatization via clear guidelines, and providing access to 1-on-1 counselors for those interested in sharing specific personal details.

Two clients and one staff member felt strongly about the value of sharing personal stories. One client noted that, “For me, I’m interested in talking about the personal experiences. I like the hope, different suggestions, and being able to connect.” A few (2) staff members also noted the potential great benefits of being more specific in discussion. One staff member noted that, “Research on trauma and homelessness suggests that specific is good.”

**Desired Outcomes**

Interviewees were asked to select their top 4 or 5 desired outcomes, what they would like to see the group help achieve. Most interviewees noted that it was not easy to select 4 or 5 from the list, since they were all important. Nonetheless, the process of trying to narrow down the focus resulted in Table 12.

Table 12. Desired outcomes, number of interviewees selecting as part of their top 4 or 5 outcomes, by order of descending number of votes.

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Staff</th>
<th>Clients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(6) Increased ability to self-regulate and teach self-regulation</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>(10) Increased ability to allow uncomfortable feelings to be expressed by children, and to help them to process these feelings in the moment, comforting and soothing them in the process</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>(2) Increased ability to recognize when a child’s behavior has</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Staff</td>
<td>Clients</td>
<td>Total</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>been affected by an event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Increased ability to discipline children in a positive way</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>(11) A greater appreciation of the value of the parent’s relationship to the child for the child’s healing</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>(1) Greater knowledge about trauma and its effects</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>(5) Greater understanding of how to help a child process the energy associated with a traumatic event (Levine, 2004)</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>(9) Increased ability to be fully present with children and connect with them in a healthy way</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>(8) Increased ability to practice self-care</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>(3) Increased recognition that certain events could be traumatic for some children and not for others</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(4) Greater knowledge about how to apply emotional first aid (Levine, 2004) immediately after a stressful event</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Overall, the majority of staff and clients agreed that outcomes #6 and #10 were important desired outcomes (Table 12). There was agreement by staff and clients on three of the top five outcomes, #6, 10, and 11. Most staff felt that #2 and 7 were important; in contrast, most clients felt that #4 and 5 were important. It should be noted that both #2 and 7 received one vote each from clients. Outcome #4 did not receive any votes from staff, although #5 received two staff votes.

Interviewees were also asked to note any other outcomes that they thought weren’t covered by the list. Only one interviewee, a staff member, had an additional outcome, but it was a key observation, namely that there be an element of hope provided by the curriculum, and that the element revolve around the idea of resiliency. Giving families realistic hope and expectations can help them from getting discouraged. The staff member also noted how there is a multi-generational aspect to trauma, and that it is a cycle that is not easily broken. The progress might be slow at times, and it is important
to highlight the family’s ability to work through these difficulties. This interviewee noted very eloquently:

An additional outcome could be resilience and hope. It’s important for parents to know that they and their children can be resilient and break the cycle, that there is hope that we can get to a place of stability and self-regulation. It won’t happen overnight, but if you stick with it, then you will see change. It’s important to be realistic, but also to give hope. One day at a time, do the best you can. If you can catch yourself one in five times, that’s a win.

One client also gave a strong endorsement of positive parenting techniques and providing positive affirmations for parenting any child that is struggling with self-esteem and negative self-talk.
How Interview Results Were Used to Inform the Curriculum

Definition of Trauma

First, based on themes of event vs. experience, negative effects of trauma, and the link between trauma and the ability to form relationships, I felt that it was important to select materials to reflect the definition of trauma and also to provide hope for healing negative effects. The interviews showed that many people already understood that trauma had an effect, though the results may not be fully representative of those that might attend the group. The curriculum still includes materials that will explore what these effects specifically look like, even though the focus is on healing.

Answers to the question, “What would make it easier to discuss the topic of trauma?” helped lead to the decision to establish ground rules in the first session. The themes of a safe, non-judgmental environment and the importance of establishing safety guidelines influenced the curriculum. My committee and I decided to start the first session with a discussion about what the group wants and what they would like the ground rules to be. We agreed that it was critical to understand what the group wanted, and to provide a safe space. Group members could use the initial discussion to decide whether they wanted to use the group as an opportunity to learn how to build trust, or to decide if they wanted a more general flavor to the discussion; this issue comes up in the later theme about personal versus general discussion also.
The committee agreed that based on previous experience facilitating groups, it is extremely difficult to interrupt the personal sharing of a group member once they started to talk about their issue. Consequently, we recommended that the facilitator suggest that, if the group wants personal discussion that they might want to ask other group members for permission before sharing something of a personal nature that could be triggering to others. This suggestion could provide group members with the awareness that their sharing could trigger others, and provide those that do not want sharing of that nature to speak before they were triggered.

The theme of a safe, non-judgmental environment and the recurring theme of blame throughout the interviews also led to the suggestions that the facilitator convey the message to participants that, “It’s not your fault.” This suggestion was inserted throughout the curriculum in several different sessions.

Understanding Effects of Trauma on the Brain

Results from this topic area and the first topic area guided the way that we address negative effects in the curriculum. I was also comforted to know that many staff were aware of the potential effects of trauma on their clients. I have confidence that staff will be able to have meaningful discussions with clients about these effects. Most interviewees understood that trauma resulted in negative effects on the brain and behavior, themes identified in Table 3. These results informed the curriculum in that it was possible to explore a deeper level of knowledge, with less time spent on the more elementary ideas about trauma.
The result that clients seemed hungrier for technical knowledge (4 or 5 rating) than staff anticipated (average of a 2.6 rating) is interesting, and could reflect a few different issues. Possible reasons for this discrepancy include: the educational level of clients interviewed may not represent the average level of clients at the MAC; clients may not realize the level of technical knowledge that is expressed in research papers; and, staff may underestimate the degree of technical knowledge that clients are capable of understanding. Regardless of the reason, I decided that a relatively high level of technical knowledge would be part of the curriculum for those clients that wanted it, mostly in the Optional Activities section. The base of the curriculum represented a middle ground for technical knowledge, closer to a 3 to 4 rating in terms of my view of the technical information, but the Optional Activities included material up to a 5 rating. Staff insight into specific effects on the brain and behavior also gave me confidence that they would be able to help explain some of the more difficult concepts of a more technical curriculum.

**Practical Tips**

The observation that all clients felt that it was equally important to understand how a child experiences trauma and what her behavior pattern may look like led to the inclusion of materials explaining why any practical tips were being made. I also included many discussion points within the curriculum, so that participants could better integrate the knowledge and ask questions.
It was interesting that 2 of the 3 clients noted the importance of self-care, even though the questions in this topic area weren’t specifically addressing that issue. Some clients seem to be acutely aware of the importance of taking care of their own needs. The curriculum development left space for exploring parent’s trauma and examining their needs and self-care practices. The week 5 curriculum is devoted to protective factors that include self-care as a major component.

The themes involved with the question of whether parents were open to suggestions led to specific discussion points for the facilitator within the curriculum. Staff had varying opinions on whether clients would truly be open to suggestions about parenting. In addition, clients and staff both agreed that the style of delivery was an important factor in determining how receptive people would be to parenting suggestions. Consequently, I relied on the use of reflective questions for discussion throughout the curriculum. Reflective questioning (Lee & Barnett, 1994) is a respectful way to inspire clients to think about what they’ve learned without lecturing to them. It allows for better integration of the material in a way that is most meaningful to the parents and also respects the fact that they are the expert in parenting their children, a comment made by one of the interviewees. The group format allows for clients to educate each other rather than having a top-down class structure. I included numerous discussions within the curriculum to allow these group education and support processes to develop organically.

The interviews inspired much thought on how to include awareness of trauma in the parents’ lives in the curriculum. One staff stated that clients may have difficulty integrating the curriculum content due to the multi-generational effects of trauma. We
included space for some discussion of adverse childhood experiences (ACEs) in the context of protective factors during week 5 of the curriculum. Allowing for discussion of a personal nature, if the group desires, can also help stimulate conversation about the parents’ own traumas. The curriculum suggests that the facilitator mention the availability of individual counseling within the general format of the curriculum. Although treatment of the parent’s trauma is not the focus of the curriculum, parents may be able to explore their trauma in greater detail with the help of a professional. The emphasis on safety guidelines, beginning with the first session, also recognizes that parents have dealt with trauma themselves and may be susceptible to re-traumatization. The inclusion of self-care in the curriculum also recognizes that parents are facing many challenges that may be a result of their prior traumatic experiences.

**Practical Suggestions for Re-Orienting the Brain**

Similar to what was noted earlier, we noticed how much clients felt strongly about understanding the reasons why activities may be healing. Therefore, we included the link between activities and why they work as much as possible. Throughout the curriculum, I made a practice of presenting the reasoning for why an activity might be useful before presenting the details of the activity.

The emphasis on practical knowledge in interviews resulted in creating a curriculum with many alternate activities. I included a large number of links and resources that specifically explain how to do certain activities. The curriculum provides direction to practice certain activities in many of the weeks.
Format of the Group

Based on feedback regarding format, we decided that it was important to respect people’s feelings about the harshness of the word trauma. It was striking that there was much hesitation in attending if the word was included in the title, and that only three of eight people that expressed hesitation would actually attend the class if the name was in the title. Therefore, I picked, “Coming out of Rough Waters: Tips for Parents Helping Their Children Through Difficult Times”—a combination of client and staff suggestions that best captured the essence of the class.

In terms of how information was presented, I relied heavily on the use of videos and discussion, the two main preferences for both staff and clients. I also included some of the rest of the suggested methods such as handouts, Microsoft Powerpoint slides, reading and writing exercises, and role-playing.

Regarding personal versus general discussion, we respected the interviewees’ diverse opinions by giving the group the opportunity to discuss what they wanted from the class in the initial discussion of week 1. I provided an opportunity for people to talk about difficult issues such as confidentiality, potential re-traumatization, and trust, based on my committee’s experience in facilitating groups. The facilitator does have the discretion to include rules that keep the group safe, however their role is more so as a guide for helping the group decide on the best format. My intention is to let the group dictate what is most important to them. I simply provide reflective questions in the curriculum that guide the group in considering how they are going to support each other
in a way that promotes safety and trust. Much thought and discussion was put into the week 1 curriculum to allow for the best balance between group empowerment and safety.

**Desired Outcomes**

The identification of key desired outcomes played an important role in selecting the subject matter for each week of the curriculum. The top 6 desired outcomes (Table 12) were directly related to the focus for weeks 2, 4, 6, 8, 9, and 10. The four outcomes at the bottom of Table 12 were also included within the context of the curriculum for weeks 1, 5, 8, and 9. The additional outcomes noted by interviewees, hope, resilience, and positive parenting, were also included in the curriculum. Hope and resilience was the central focus of week 3. The idea of positive parenting was covered during week 10 under positive discipline.

**Social Work Implications (What was Learned)**

I gained greater insight into clients’ challenges and desires by interviewing clients and staff at the MAC. The interview process was empowering, because it allowed clients to have a voice in getting help the way that they want to be helped, an important part of social work practice (Gai, 2013). Understanding the client is critical for helping us design interventions (such as this project) that are the most meaningful for the client.

I learned from the interviews that clients often felt like they were being blamed. Clients mentioned numerous times that it was important to note that it’s not their fault, that nobody was to blame when it comes to effects of trauma on their children. I gathered
from these comments that clients may have felt like they were being blamed in the past, due to oppressive systems and victim-blaming. Helping clients overcome such challenges is a critical part of being a social worker. Clients often do not feel safe enough to be fully honest in institutional settings such as the MAC, so providing them with an opportunity to build that trust and safety with each other not only provides a healing space, but also gives them the power to better understand how they can help each other. It is our role as social workers to help guide the process at first, but to step back when clients no longer need our help.

Clients expressed a strong interest in self-care, noting its importance even during questions where this was not asked. I think this is an important finding, because it shows that the clients understand the importance of self-care based on their experience. This knowledge can help them to become a sustainable resource for their children. It is also a reminder for the social worker that self-care is an important aspect in client care. For us to be effective social workers, we must devote effort into taking care of ourselves in this demanding profession.

Overall, staff expressed compassion, understanding, and empathy towards the families they work with, despite some frustration about the difficulties in communicating and connecting with their clients. Key staff seemed to have a good understanding of the clients overall, and were sensitive to ideas about how the information needed to be delivered. There seems to be an underlying perception by some staff members that clients are less capable than they think they are, and that they should be less resistant to suggestions than they are. More experienced staff members seemed to be less judgmental
about the natural resistance of clients to being told what to do by authority figures, and “roll” with that resistance. I speculate that many of these lessons were hard-earned and were the product of valuable experience working with clients. Therefore, it seems that staff retention is a critical piece in helping maintain and improve quality of care for these vulnerable clients.

Legacy and Next Steps

The legacy of this project is sensitive implementation by caring staff and continued implementation by clients themselves. We were pleased to find that some staff members were aware of the multi-generational nature of trauma. Many of them also expressed an understanding of the need to be patient with clients’ progress. These observations bode well for the legacy of implementation.

We designed the project to help encourage clients to participate in their own education and growth that goes far beyond the institution. We hope that they will carry what they learn to the next generation, who will carry it forward to their children. In this way, we hope that the project can become an instrument to break the cycle of trauma in family’s lives.

In terms of practical considerations, the MAC will be transitioning from a transitional living facility for families to a rapid-rehousing model for singles. Staff at the MAC will, however, continue to support families in their satellite facilities. They expressed willingness and enthusiasm to use the curriculum with these families. The next logical step would be to provide evaluative surveys of the curriculum to clients, formal or
informal, during and after implementation of the curriculum. Surveys could include questions such as: What was helpful or meaningful to you? And what was less helpful? How can we do better? These are critical evaluative questions that will be important to consider in any future interventions.

The message that we hope to convey to clients with implementation of this project is that it’s not your fault, it’s not easy, and we are here to help you along in your journey. We can’t walk it for you, but we can walk it with you. After you’re done here, we hope that you’ve found some new friends and support along the way that will stick with you long-term. We also hope that we have provided you with the skills and knowledge to further develop coping and healing strategies that are meaningful to you and your family. The message is one of hope and resilience that can help break the multi-generational cycle of trauma. The process begins with us as social workers in collaboration with our clients. It continues with our clients continuing to grow and change in a positive way that is their own way. We can begin to heal trauma by empowering our clients to utilize their own strengths and foster their own resilience.
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Appendix A – Topic Guide

Trauma Education Curriculum Topic guide – MAC Clients and Staff

How do you define trauma?
What might make it easier to discuss this topic with other? What would make it more comfortable for you?

Understanding the effects of trauma on the developing brain
What do you currently know about trauma? What have you heard about it?
What level of background information on trauma is useful or interesting to you? (In terms of scientific/technical knowledge, on a scale of 1 to 5, with 5 being the most technical, what would you prefer?) An example of the most technical knowledge (5) might include exploring research articles about specific effects of trauma on the brain as well as specific parts of the brain that are affected; the least technical knowledge (1) might note that research had shown that trauma effects the brain, but not get into specific detail about how.

Practical tips for how to recognize the effects of trauma on children, and what to do in the moment to help settle your child
Are you more interested in how your child may be affected and what their experience is like, or in understanding what the effects look like in their behavior? Or some combination of the two?
Would you be open as a parent to suggestions about how to help your child cope better?
Is there anything that would help to make that process more comfortable to you?
Practical suggestions for re-orienting the brain

Are you interested in understanding why certain activities may be beneficial for helping re-orient the brain, or are you more interested in learning what activities to try with your child given certain behaviors? Or some combination of the two?

Format of the group

What would you name a class focused on this topic? What would your reaction be to a group that had the word trauma in its title and as the main part of the curriculum? Would you have some hesitancy about attending?

How do you like to see information presented? Video, audio, slide presentations, discussion? Some mixture? How much of each do you like? (i.e., more video than discussion, etc.)

Are you interested in a group where you can talk specifically about different personal experiences your child may have had with trauma and their response to that, or are you more interested in general discussion about the topic of trauma and its effects?

Desired outcomes

I would like your input on potential desired outcomes for the curriculum. Here are 11 potential outcomes to get us started. Which are of greatest interest to you? What additional ones would you be interested in?

Potential desired outcomes:

1. Greater knowledge about trauma and its effects
2. Increased ability to recognize when a child’s behavior has been affected by an event
3. Increased recognition that certain events could be traumatic for some children and not for others
4. Greater knowledge about how to apply emotional first aid (Levine, 2004) immediately after a stressful event
5. Greater understanding of how to help a child process the energy associated with a traumatic event (Levine, 2004)
6. Increased ability to self-regulate and teach self-regulation
7. Increased ability to discipline children in a positive way
8. Increased ability to practice self-care
9. Increased ability to be fully present with children and connect with them in a healthy way
10. Increased ability to allow uncomfortable feelings to be expressed by children, and to help them to process these feelings in the moment, comforting and soothing them in the process
11. A greater appreciation of the value of the parent’s relationship to the child for the child’s healing
Appendix B – Informed Consent Form

Consent Statement (Part 1)

I am a student researcher, and this interview will be used to inform a Social Work Master’s project. You are being asked to participate in a study that involves answering questions and providing feedback on developing a multi-week curriculum to be used at the MAC. The duration of the interview is expected to be 15 to 20 minutes. Interviews will occur on site at the MAC. The intention of gathering this feedback is to provide you with an opportunity to contribute to a curriculum about trauma education. The purpose of the project is to develop a curriculum around trauma education that informs parents about the effects of trauma on their children and provides practical suggestions on how to help your children cope with and heal from the effects of trauma. There will be no direct benefits, and the indirect benefit would be for you to know that you are contributing to a curriculum that may benefit others.

If you agree to participate, you will be asked to provide feedback about four topics being considered for the curriculum. The questions asked during the interview are not expected to cause any risk or discomfort beyond what is typically faced in daily life. You may stop participation at any time. Written notes will be taken during the discussion. We will make every effort to keep your answers confidential; however, the researchers are mandated reporters. Any information or concerns you share about current abuse or neglect of any minor are reportable under California's Mandated Reporter law.

For the purposes of this project, the student researcher will know your identity, but nobody else will. Any data that will be publicly available will be included in a summarized format without any identifying information. The data will be summarized as part of a Master’s Project for the Department of Social Work at Humboldt State University; this project will be made publicly available. The findings will primarily be reported as group patterns; however, it is possible that something you say could be quoted, if you agree to be quoted below. Your identity will not be linked to your quote if this occurs. Thank you for your participation.

I understand that participation in this survey is completely voluntary, and refusal to participate will not involve any penalty or loss of benefits to which I am otherwise entitled. I may stop my participation at any time without penalty or loss of benefits. I understand that the investigator may also end my participation at any time during the interview. If you have questions about the interview please contact Dr. Jen Maguire in the HSU Department of Social Work at (707) 826-4565 or Jennifer.maguire@humboldt.edu. If you have any concerns regarding this project, you may contact the IRB Chair, Dr. Ethan Gahtan, at eg51@humboldt.edu or (707) 826-4545. If you have questions regarding your rights as a participant, you may report them to the IRB Institutional
Official at Humboldt State University, Dr. Rhea Williamson, at Rhea.Williamson@humboldt.edu or (707) 826-5169.

Name

Email Address

Phone Number (____)_______________

Is it ok to quote you in the Master’s Project report? No identity will be linked to the quote if so.

☐ Yes

☐ No, please don’t quote me at all in the Master’s Project report.

_________________________  _______________________
Signature of Participant      Date
Consent Statement (Part 2)

I am a student researcher, and this email communication will be used to inform a Social Work Master’s project. You are being asked to participate in a study that involves providing feedback on developing a multi-week curriculum to be used at the MAC. The intention of gathering this feedback is to provide you with an opportunity to contribute to a curriculum about trauma education. The purpose of the project is to develop a curriculum around trauma education that informs parents about the effects of trauma on their children and provides practical suggestions on how to help children cope with and heal from the effects of trauma. There will be no direct benefits, and the indirect benefit would be for you to know that you are contributing to a curriculum that may benefit others.

If you agree to participate, you will be asked to provide electronic feedback about the draft curriculum. The discussion about the curriculum is not expected to cause any risk or discomfort beyond what is typically faced in daily life. You may stop participation at any time. Your feedback will be used to revise the curriculum where it seems relevant. We will make every effort to keep your answers confidential; however, the researchers are mandated reporters. Any information or concerns you share about current abuse or neglect of any minor are reportable under California's Mandated Reporter law.

For the purposes of this project, the student researcher will know your identity, but nobody else will. Any data that will be publicly available will be included in a summarized format without any identifying information. The data will be summarized as part of a Master’s Project for the Department of Social Work at Humboldt State University; this project will be made publicly available. The findings will primarily be reported as group patterns; however, it is possible that something you write could be quoted, if you agree to be quoted below. Your identity will not be linked to your quote if this occurs. Thank you for your participation.

I understand that participation in this feedback process is completely voluntary, and refusal to participate will not involve any penalty or loss of benefits to which I am otherwise entitled. I may stop my participation at any time without penalty or loss of benefits. I understand that the investigator may also end my participation at any time during the interview. If you have questions about the interview please contact Dr. Jen Maguire in the HSU Department of Social Work at (707) 826-4565 or Jennifer.maguire@humboldt.edu. If you have any concerns regarding this project, you may contact the IRB Chair, Dr. Ethan Gahtan, at eg51@humboldt.edu or (707) 826-4545. If you have questions regarding your rights as a participant, please consult with the IRB Institutional Official at Humboldt State University, Dr. Rhea Williamson, at Rhea.Williamson@humboldt.edu or (707) 826-5169.
Name ____________________________________________

_____________________________________

Email Address ____________________________________________

Phone Number (____)___________

Is it ok to quote you in the Master’s Project report? No identity will be linked to the quote if so.

☐ Yes

☐ No, please don’t quote me at all in the Master’s Project report.

_______________________________________  _______________________

_____________________________________

Signature of Participant                     Date
Appendix C: “Coming out of Rough Waters: Tips for Parents Helping Their Children Through Difficult Times”, Trauma Education Curriculum

Purpose of the Curriculum Overall: To address the need of developing effective research-based curriculum that will help empower homeless families in their efforts to heal from the effects of trauma.

Week 1: Introduction (Establishing Trust)

Desired outcome: The group will have guidelines that allow for meaningful dialogue, safety, and trust.

Notes to facilitator: This session is intended to help establish guidelines that emphasize trust and confidentiality, and allow the group to decide on the level of personal sharing that they would like in subsequent sessions. Activity 2 may take up the entire session, depending on the group. This session, as currently organized, could be divided into two parts if needed. It may be useful to develop a short summary of guidelines/ground rules (e.g., 3 sentences) that can be read before starting each session in the future, based on the group discussion during this week’s session.

Day at a glance:

Activity 1 (3 min): Elevator pitch (3 sentence description on what the overall purpose of the class is, and the desired outcomes).

Activity 2 (15 to 45 min): Confidentiality and trust discussion.

Activity 3 (10 to 30 min): Defining trauma (MS Powerpoint slides).

Detailed activity plan:
Activity 1: Briefly describe what the class is about.

The curriculum is meant to help parents better understand the effects of trauma on their children, and to learn ways to help their children cope with these effects. By the end of the curriculum, you will be able to: recognize when a child is being affected by a traumatic event; understand how your relationship as a parent can be healing; self-regulate and be able to teach self-regulation; be present for and help your children process difficult emotions; and utilize positive discipline in parenting. You will also learn specific activities that you can do with your child to specifically address the effects of trauma.

Welcome, check in, with “Who are you? Why are you here? What would you like folks to know about you?”

Activity 2: Confidentiality and trust discussion.

We feel that it is important to discuss confidentiality in the open, and that people agree to some basic understandings and guidelines for the group to be a safe place for all group members.

The facilitator may want to begin the session (or cover these points during the discussion above) with the following:

- There are a few key issues that come up with personal sharing. One is confidentiality and another is the potential for re-traumatization.
- We realize that there are limits to what we can promise as facilitators regarding confidentiality. For instance, sometimes words spoken in confidence can be used against people (in a vulnerable moment). Also, the facilitators are mandated reporters.
- It may be to your best interest to talk more about the impact of your experiences in a general way, rather than discussing specific details of the traumatic
experience; however, if participants agree, this could also be an opportunity to work on building trust.

- There can be trust issues that arise due to past trauma; trauma can be viewed as a relational event. Sharing stories may be an opportunity to rebuild trust. (Is the group interested in this?)
- You may want to ask people before sharing a detailed personal story if it is ok to do so.
- Note that it is difficult for a facilitator to stop people once they have begun sharing personal details of a story that is important to them; so, we ask that participants please take care of themselves by temporarily leaving if they need to or asking help from one of the facilitators if re-traumatization is an issue.
- Even though trauma may have happened in your family, you have many strengths that can help you overcome trauma. The fact that you’re here shows you are resilient, and that you can be resilient for your children.
- If you are feeling any shame, please talk to the facilitator; they can help you with any difficult feelings that arise.

Discussion points:

- What does confidentiality mean to you?
- Why is it important to you?
- How interested is the group in personal story-telling?
- (There is no pressure to disclose; it is your choice.)

Solicit input:

- What do you want the rules of the group to be?
- (How many people are interested in more personal discussions?)
- (How many are more interested in general topic matter?)
- (What level of technical information are people interested in, on a scale of 1 to 5, with 5 being the most technical?)

Activity 3: Defining Trauma MS Powerpoint (see slide content below).

The facilitator may want to note that trauma is a perceived threat, unique to the individual, as they present the two slides below:

Slide 1.
Trauma Defined

- "Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety." (SAMHSA, n.d., http://www.samhsa.gov/nctic/default.asp)
- "From a neurological perspective, trauma is not the event—it is the individual’s response to the event." (Ungar & Perry, 2012, p. 126)

Slide 2.

Neurodevelopment and Neurobiology, Key Principles (from Perry, 2006)

1. Organization of the brain is hierarchical (famous brain diagram; requires positive corrective experiences to remedy false negative associations)
2. The brain’s systems change in a use-dependent way (Abstract, concrete, etc. thinking; Fight, flight, or freeze; repetition and patterns through multiple adults doing same interventions; need many positive interactions and many repetitions beyond weekly therapy)
3. Brain develops sequentially (treatment must be sequential, from lower parts of brain to higher; if lower is dysregulated, upper levels will be as well; EMDR, drumming, dancing, patterned massage, patterned rhythmic activity useful and quiets the brainstem, but has to match where the child is at)
4. Most rapid development of the brain is during early childhood (90% of brain size by age 4) [the earlier the intervention, the better; see Table3.1]
5. It is possible to change neural systems, but some are much easier to change than others (cortex much more plastic and changeable than lower portions of brain; takes a great deal of repetition to address change in the lower brain)
6. Human brain designed for a rich relational environment, 4:1 adult to child ratio (compared to current day “best practice” of 1:4 adult to child ratio)
For a list of experiences that can be traumatic, see

http://www.nctsn.org/resources/audiences/parents-caregivers (Consider printing as handout).

_Brain development_ (potentially another handout):

- A child’s brain by age 4 is 90% of the size of the adult brain (Perry, 2006).
- The brain requires a stimulating learning environment to provide learning opportunities.
- In Indigenous communities, such an environment has been provided by ceremonies, clan teachings, and strong extended families (which provide for language development and social connections).
- Our brains have evolved with a strong parent to child ratio of 4:1 (http://childtrauma.org/wp-content/uploads/2013/08/Perry-Bruce-neurosequentialmodel_06.pdf), and that that ratio has been flipped in today’s society.

_Closure:_

Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.
Next week’s topic is: “Understanding the Effects of Trauma on the Brain”
Week 2: Understanding the Effects of Trauma on the Brain

*Desired outcome:* You will have a greater understanding about the effects of trauma on the brain.

*Notes to facilitator:* I’ve provided a placeholder to read a brief summary of guidelines/rules that the group came up with in Session 1 prior to doing check-ins. In the “Optional Activities” section, I’ve provided a link to what I think is a great video for folks dealing with domestic violence; it also has quite a bit of input from Bruce Perry and others in the neuroscience field, but is more specific to trauma related to domestic violence. This might be a good option for smaller groups or an additional private 1-on-1 session for parents that do not want to discuss domestic violence in the group.

I also included a great link ([https://www.youtube.com/watch?v=uOsgDkeH52o](https://www.youtube.com/watch?v=uOsgDkeH52o)) at the end of the “Optional Activities” section that is more technical in nature. It is Bruce Perry explaining the way that the brain works, and really gets into detail about the hierarchical nature of the brain, including how the senses are processed by the brain.

I also have a suggested hand-out for those more technically inclined (it may be enough to print out one or two copies for people to see, and decide if they want to have a copy). It’s a great article by Bruce Perry (2006) that describes the effects in a way that is somewhat technical, but not overly so.

*Day at a glance:*

*Activity 1 (50 mins.):* View video and discuss.

Handout: One copy of Perry (2006), see link below, could be on hand during the group and made available to anyone that wanted.

*Detailed activity plan:*
Today, we will be watching a video about the effects of trauma on the brain and relationships.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust…."

Check-in: How did last week go for people? Now that you’ve had a chance to reflect, how are you feeling about trust and safety in the group?

Activity 1: Video, *Trauma, Brain & Relationship: Helping Children Heal* (video), and discussion, https://www.youtube.com/watch?v=jYyEEMIMMb0

Introduce the Video: The purpose of watching the video is so that we can gain a greater understanding about the effects of trauma on the brain, and how it affects our children and their relationships. We will be stopping the video periodically, so that we can have some discussion about it.

Suggested stopping points for the facilitator:

[0:00 to 5:55] (Highlights the importance of relationships, state-regulation, and attachment bonds)

Discussion points:

- How is it going so far?
- What feelings is this bringing up for people?
- The facilitator can emphasize the importance of relationships in healing

[5:55 to 10:50] (Explores some of the causes of trauma, and some of the warning signs you’ll see)

Discussion points:
• Do you notice any of these signs in your child?
• (It’s not your fault)

[10:50 to 17:15] (Attachment figure as source of trauma; “What’s sharable is bearable.”)

Discussion points:
• Are there some difficult feelings coming up with this portion? (Some of it may come across as blaming, but it’s not meant to be that way. It’s not your fault.)
• What do you notice that you’re feeling? What do you notice in your body?
• What do you think of the idea of treating the entire family? (We are here as a resource 1-on-1 anytime, if there is interest in this.)
• What do you think about the trauma story? [We will get into this further in other sessions.]

[17:15 to 19:00] (Pre-verbal with young children; parents can communicate that they understand non-verbally.)

Discussion points:
• Is this part helpful?
• How often do you notice non-verbal signals with others and with your children?
• What non-verbal signals do you think that you give to others?
• What positive things from the video do you already do with your children?

[19:00 to 23:30] (Resilience and hope)

Discussion points:
• What stood out for folks?
• Do you have any examples of resilience and hope that you can share, strategies that you’ve used with your family?
• Even one adult (one secure relationship) can make a huge difference in a child’s life.
• Being more emotionally present helps a great deal; your emotions mean a lot to the child; we’ll talk more about how to help your child with difficult emotions later.
• Not all traumatic events lead to poor outcomes; there is hope.
• We can stop the cross-generational trauma; beginning the process of self-understanding is really key to that process.
At the end of the video, the facilitator could emphasize 3-4 talking points about video:

- Relationship is the most important and most powerful healing agent of trauma in young children
- We can help children become more able to participate in and benefit from positive relationships
- More often than not: perfection is not required

Discussion points:

- Do you see examples of what the video was talking about in your own family?"  
- How did that make you feel as a parent? Was that difficult to watch? What did you notice about your reaction? Where did you notice that reaction/feeling in your body?  
- Did you relate to any of it? Do you see any of that in your family?  
- What can you identify about specific effects on the brain?  
- What about the video gave you hope?

Key messages from the facilitator:

- This is your group.  
- It’s not your fault.  
- This is a safe place.

Handouts/Resources:


Closure:

Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?  
- What was useful about the session? What did you find not as useful?  
- What would you like to see more of?  
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?
(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

*Next week’s topic is:* “Hope and Resilience”.

*Optional Activities*

(Applicable if working specifically with families affected by domestic violence):

Today, we will be watching a video that explores the effects of domestic violence on children’s behaviors and brain activity. Even though the following video is not graphic, the content could trigger some people. Please take care of yourselves, and leave the room to take a walk if need be. Each segment will be about 5 minutes in length, and it will be possible to talk about your experience with watching the video between segments. The video is available at:

https://www.youtube.com/watch?v=jYyEEMIMMb0

Suggested viewing intervals:

[0:00 to 6:27] (Signs like night terrors, chronic stress, difficulty with attachment, bx presenting like defiance; part of survival strategy)

Discussion points:
• What is it like for people to be watching this?
• Do you recognize any of these signs in your children? Do you relate to it?
• (It’s not your fault.)

[6:27 to 11:25] (Instability creates uncertainty, lack of safety; baby’s internal states mirror parents’; don’t have to do it alone; brain has great capacity for change; bringing in other healthy adults is helpful)

Discussion points:

• What’s it like to hear this? What emotions come up for you?
• You as a parent don’t have to do it alone; other trustworthy and healthy adults can also help.
• The ability of the brain to heal itself is strong and gives hope.
• (It’s not your fault.)

[11:28 to 13:22] (Building resilience, healthy self-regulation; parent as expert, model)

Discussion points:

• What did you think of this last part?
• Was this video helpful?
• What did you see that gave you hope? What was challenging for you?

An excellent Perry link that explains the more technical aspects of the brain architecture:

https://www.youtube.com/watch?v=uOsgDkeH52o

More about brain development than self-regulation, a nice simple explanation of brain development (Part 2 of Regena Melrose, self-regulation:

https://www.youtube.com/watch?v=o9LHvJwj-PQ)
**Week 3: Hope and Resilience**

*Desired outcome:* You will have a greater understanding of the concept of resilience and be able to identify that quality in your family.

*Notes to facilitator:* There are options for Activity 1 video in the “Optional Activities” section. The current video is short, and may or may not spark much discussion. The book, “The Boy who was Raised as a Dog” (Perry & Szalavitz, 2008) is a great easily understandable resource, and there is a fantastic study guide (Child Trauma Academy, 2014) that is available online (I’ve included the link below). The study guide was designed with teachers in mind, but could be easily adapted for use with the group (or with interested staff). I’ve included an activity which uses one of the questions, though it may be more appropriate as the primary activity.


You may want to pick and choose specific sections to explore with the group.

*Day at a glance: Summarize what the activities are, outline...*

**Activity 1:** Brief video and discussion (20 min).

**Activity 2:** Read and write exercise with “The Boy who was Raised as a Dog” (Perry & Szalavitz, 2008) (30 min)

*Detailed activity plan:*
Today, we are going to view a short video and a few powerpoint slides about resilience.

The reason why resilience is important is that it can help reduce the possibility of negative outcomes, despite the presence of many risk factors. We will then have some discussion about what that means to you, and we will have an activity that explores resilience further.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust…”

Check-in about any thoughts about the video viewed last week.

Activity 1 (Andrade video and discussion):

[View short excerpt from Andrade (https://www.youtube.com/watch?v=2CwS60ykM8s), from 0:00 to 1:20 about celebrating tenacity and resilience.]

Show MS Powerpoint slide re: resilience, see below.
**Resiliency Concepts**

- Defined as an individual’s capacity to figure out how to obtain resources, and negotiate for how their needs are met (Ungar & Perry, 2012)
- Resiliency “can only be achieved when the individual’s social and physical ecology – their environment provides the relationships and opportunities required to succeed.” (Ungar & Perry, 2012)

**Discussion points:**

- What does resilience mean to you?
- Have you seen examples of resilience in your life or your child’s life?
- How has resilience helped you or your child to cope?

**Activity 2 (Read and write exercise with “The Boy who was Raised as a Dog”):**

Read out loud, “Boy raised as a Dog” (Perry & Szalavitz, 2008), from p. 38 to p. 43.

“Resilient children are made, not born.” (p. 38).

Use the study guide question from Child Trauma Academy (2014),

One possible point of discussion could be: “After reviewing the first half of Chapter 2 and especially pp. 40-43, discuss how appropriate stress works positively to strengthen the student’s ability to both learn and maintain self-control in the classroom.”

Important points in this reading:

- Resilience cannot be assumed with children.
- In fact, they are more sensitive to trauma than adults; it’s not always obvious.
- Patterned and repetitive important when it comes to exposure to stress; the analogy of the addict and drug use.
- Sensitization vs. tolerance; sensitization means that becomes more sensitive over time, while tolerance reduces the response to a given experience over time.
- The idea of use-dependence; use it or lose it analogy with weights. Consistent or steadily increasing numbers of repetitions can help build muscles, whereas inconsistent numbers of repetitions can confuse the muscles (same with the brain, p. 40).

Closure:

Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.
Next week’s topic is: Warning Signs with respect to Trauma.

Optional Activities:

Play initial video, Trauma, Brain & Relationship: Helping Children Heal (video),
https://www.youtube.com/watch?v=jYyEEMIMMb0 from [19:00 to 23:00]; really explores hope and resilience well. Can discuss afterwards.

If the class desires highly technical material, try the following: Read Ungar & Perry’s (2012) (http://cctasp.northwestern.edu/wp-content/uploads/Trauma-Violence-and-Resilience.pdf) case examples, either taking turns reading out loud or silently, from p. 7 to p. 11. If read aloud, the class can pause for discussion at periods at the discretion of the facilitator. It would be best to stop in time to allow for any questions or understanding to be clarified.

Discussion points:

- What is your understanding of resilience based on the article?
- What do you think would have been most helpful to each of the characters in helping build resilience?
- What feelings did the reading bring up for you?

Reel youth, youtube video (3 mins., inspiring short video):
https://www.youtube.com/watch?v=1CvExk1TVMO

Might be a useful video especially for fathers:
Finally, a Bruce Perry video that might be useful, technical but really gets at how the brain’s systems adapt to the environment and how providing predictable stimuli can increase tolerance vs. how having chaotic stimuli can develop extra sensitivity. (Resilience comes in about 6:18, with the idea that predictable stressors help lead to resilience; also gets into differential state reactivity, goes well with Ungar & Perry, 2012):

https://www.youtube.com/watch?v=qv8dRfgZXV4

Technical video (and she seems to be reading, but theme of community resilience, important relationships, importance of empathy & difficult times):

https://www.youtube.com/watch?v=P8nMgY5dkTs

(about 11 min mark to 16:25 is where resilience is spoken about).

[This is also a great blog post that talks about Daniel Siegel’s ideas in a simple and concise way, highlighting how resilient children come from, and also models for parents what to do after they lose it (something that is also explored in the later session on Positive Discipline): http://www.thetwincoach.com/2011/06/compassionate-resilient-children-begin.html

Another great blog post that is a follow up to the first one noted above, which covers in detail the workshop the blog writer attended with Daniel Siegel and Tina Bryson, the

(It covers a little bit on left brain vs. right brain, connecting and redirecting, understanding why children misbehave, the idea of discipline as a teaching moment, downstairs vs. upstairs brain, how to help your child develop the upstairs brain, the downside of timeouts.)
**Week 4: Warning Signs**

*Desired outcome:* You will be better able to recognize warning signs for the effects of trauma in your child.

*Notes to facilitator:* I included a 5 minute segment from the initial video (from Session 2), because it is so relevant here; I also included another option from the DV/trauma video that is applicable.

The warning signs from the NCTSN website may be worth printing as another hand-out. May want to consider breaking into small groups or pairs before discussing. It may also be worth viewing online, so that parents can see what kind of resources are available to them.

I really like Peter Levine’s (2004) audio (an audio download can also be purchased for ~$10 from http://www.soundstrue.com/store/it-won-t-hurt-forever-4914.html or we can see about other options for getting the audio); Track 3, 4:00 to end is especially useful for this week’s topic; I talk a bit about it in the “Optional Activities” section.

*Day at a glance:*

Activity 1 (20 to 30 min): View video and have discussion regarding possible warning signs.

Activity 2 (20 min): Go over handout(s) and discuss whether parents are seeing any of these signs in their children.

*Detailed activity plan:*
Today, we are going to replay parts of the videos specifically addressing warning signs of trauma for your child, to help you be able to identify them better. Then, we will review a few handouts that explore more specific warning signs in detail.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust….”

Check-in about any thoughts about the video viewed last week.

Activity 1 (View video and discuss)

From 5:55 to 10:50 in initial video, *Trauma, Brain & Relationship: Helping Children Heal* (video), explores some of the causes of trauma, and some of the warning signs you’ll see, [https://www.youtube.com/watch?v=jYyEEMlMMb0](https://www.youtube.com/watch?v=jYyEEMlMMb0)

And/Or

From 0:00 to 6:27 in the DV video, [https://www.youtube.com/watch?v=jYyEEMlMMb0](https://www.youtube.com/watch?v=jYyEEMlMMb0)

(Explores signs like night terrors, chronic stress, difficulty with attachment, bx presenting like defiance; part of survival strategy)

Discussion points:

- What is the difference between a hyper-aroused and dissociative stress response?
- Do you relate to any of these descriptions?
- Where do you see your child in this? Does it apply?

Handouts:

Warning signs identified by: [http://www.nctsn.org/resources/audiences/parents-caregivers](http://www.nctsn.org/resources/audiences/parents-caregivers)

for different developmental stages (see the “Understanding Trauma” tab).
Warning signs which occur after a traumatic event (Levine, 2004):

Fearfulness
Withdrawal
Irritability
Emotional outbursts
Excessive shyness (e.g., clinging)
Trouble sleeping (nightmares, nightly thrashing in bed)
Exaggerated startle responses
Regression to past behaviors (e.g., thumb sucking, bed wetting)
Avoidant (possibly developing phobias)
Physical symptoms (fevers, constipation, diarrhea, headaches, stomachaches)

Note that physical symptoms could result from an illness like the flu, but they will tend to get better with time; if these symptoms are due to trauma however, they will probably get worse over time (Levine, 2004).

Don’t have to wait until full blown symptoms; can act at early signs or right after the event (Levine, 2004).

As a parent, it can be easy to be in denial, and it’s possible to miss some of these signs (Levine, 2004).

Discussion points:

• Are you seeing any of these signs in your children?
• Which ones seem to be most relevant for you? What does that look like in your child?
Are there things that you do that seem to help?

Closure:

Depending on time left in the session, the facilitator could ask the group:

• How did that go for everyone?
• What was useful about the session? What did you find not as useful?
• What would you like to see more of?
• What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

Next week’s topic is: Protective factors.

Optional Activities:


Chapter 2: “3. Discuss the difference between a stress response that is hyper-aroused and one that is dissociative? Think of examples of students that fit each descriptor and discuss how teaching and discipline can be handled best in both cases.”]

Chapter 8: “1. After examining Amber’s case, detail the signs of a dissociative threat response that you might recognize in students in your school?”] Although it is stated for in school, can adapt it to say in your home.

Play Levine (2004), Track 3, from 4:00 to end of track. This would be the audio version of what’s stated in the latter portion of the hand-out.

Consider following for handout:

Track 4 (Trauma and the shock reaction, 5:43), [Like the slinky example] (Levine, 2004)
Tremendous energy called forth by the body; if a child is younger, they are less able to discharge the energy, and have a greater chance of being affected by the trauma reaction later.

“Energy is all dressed up with nowhere to go.” (Levine, 2004).

Example of mothers pulling cars off of children; action allows the energy to be discharged.

However, if it is not discharged through action, it must be released somehow. Animals shake and tremble, as do human beings. A child may also do the same, trembling, shaking, crying. It is important not to stop them.

Athens earthquake example: Children couldn’t sleep; they had symptoms like stomachaches, nightmares. They shook a lot, and parents all stopped them. When the doctor suggested that the parents allow the children to shake, and simply support them in that process, the children were able to sleep again. It was the body’s natural reaction for “returning to equilibrium”. This is a natural process.
Week 5: Protective Factors

Desired outcome: You will be able to identify protective factors in your family and begin work on developing/refining protective factors.

Notes to facilitator: This week’s content is based primarily on Wolf (2012), http://www.strengtheningfamiliesillinois.org/mirror/downloads/LPF_6_Web.pdf, and incorporates a few selected exercises from that document. Note that there are numerous activities throughout this document that the facilitator can choose ones that may suit their current clients best. Wolf (2012) is organized around 3 main parts: self-care, parenting, and relationship-building. These activities could also be used for other weeks of the curriculum, particularly the ones on Self-regulation and Importance of the parental/caregiver relationship.

There is also an excellent video at the beginning of the Optional Activities section from Nadine Burke Harris that could take the place of the current Activity 1. It really hits home about the effects of ACEs on us as adults.

Day at a glance:

Activity 1 (25 mins), View short Powerpoint and discuss risk and protective factors.

Activity 2 (25 mins), Review handout on protective factors and discuss

Detailed activity plan:

Today, we are going to discuss protective factors that can help you as a parent to help your child cope better with life. Then, we are going to try a few exercises that might be helpful for building some of these protective factors.
[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust…."

Check-in about any thoughts about the video viewed last week.

Activity 1 (Show Powerpoint slides, and discuss; see slide content below, could also be a handout).

Slide 1.

ACEs study (CYW, 2014)

Adverse childhood experience defined as a traumatic experience in 3 different areas:

- Neglect (Physical or emotional)
- Abuse (Physical, emotional, or sexual)
- Household dysfunction (Domestic violence, mental illness, incarceration, substance abuse, divorce)

Adverse childhood experiences lead to many mental and physical health problems, in addition to economic and social challenges.

Humboldt and Mendocino counties rated the highest of CA counties for percentage of adults with ≥4 ACEs (30.8%)
In comparison, average % with more ACEs in CA is 16.7%

Slide 2.
ACEs continued (CYW, 2014)

- 5.1 times more likely to have depression
- 3.2 times more likely to binge drink
- 3.3 times more likely to participate in risky sexual activities.
- 12 times more likely to be a victim of sexual violence (after age 18 years).
- 39% more likely unemployed
- 13 times more likely to be removed from the home
- 2.4 times more likely to have heart disease

Slide 3.

Hope and Protective Factors

However, there is still hope.

The road is long, and it will take lots of work, but risk factors are not completely predictive of outcomes.

Why is that? Protective Factors!

Resiliency strongly related to protective factors such as key relationships (Ungar & Perry, 2012)

However, protective factors are not naturally given, but developed
http://www.strengtheningfamiliesillinois.org/index.php/main/content/category/for_parents
And
http://www.bestrongfamilies.net/

Discussion points:
• What comes up for folks when they see these facts and figures?
• (It’s not your fault)
• We recognize that many folks may have been through ACEs during their childhood; there is no judgment about you or your children. Trauma and adversity happen to many of us.
• Our goal is to provide you with hope and ways of coping and building protective factors to end up with positive outcomes.

Activity 2 (Review handout on the 6 protective factors from Wolf (2012))

Handout:

Handouts (provide the list as well as the links; this might work better for clients if emailed, or stored in a google drive that clients could access):

Present one version of protective factors that has been useful for families, from

http://www.strengtheningfamiliesillinois.org/index.php/main/content/category/protective_factors:

“Protective Factors:

1. Enhance Parental Resilience (Be strong and flexible)
2. Develop Social Connections (Parents need friends)
3. Build Knowledge of Parenting and Child Development (Being a great parent is part natural and part learned)
4. Offer Concrete Support in Times of Need (We all need help sometimes)
5. Foster Social and Emotional Competence (Parents need to help their children communicate)
6. Promote Healthy Parent-Child Relationships (Give your child the love and respect they need)"

[Expand and explain these a bit. The links help to explain quite a bit.

http://www.strengtheningfamiliesillinois.org/index.php/main/content/category/protective_factors]

Quotes:
#1: “If parents were treated harshly themselves as children, they may need role models, resources, and encouragement to be able to deal with challenges while nurturing their children.” (from http://www.strengtheningfamiliesillinois.org/index.php/main/content/protective_factor_1/)

#2: “When parents have an informal network of trusted friends in their community, they have a support system for meeting both practical and emotional needs. They can brainstorm about problems together, give and receive back-up child care, and help meet unexpected needs such as transportation. As a social group, parents provide each other with norms for how family and community issues should be handled.” (from http://www.strengtheningfamiliesillinois.org/index.php/main/content/protective_factor_2/).

#3: “Parents who understand normal child development have reasonable expectations for their children. Parents who have alternative strategies for dealing with children’s challenging behavior can avoid harsh punishments.” (from http://www.strengtheningfamiliesillinois.org/index.php/main/content/protective_factor_3/).

#4: “Everybody needs help sometimes, and families that can get help when they need it are able to stay strong and healthy. Whether the need is caused by a sudden crisis—like a death in the family or loss of employment—or an ongoing issue such as substance abuse or depression, being able to ask for and receive help is important to keeping families strong.” (from
http://www.strengtheningfamiliesillinois.org/index.php/main/content/protective_factor_4/).

#5: “Parenting can be especially difficult when children act out or exhibit challenging behaviors. When children can communicate their feelings appropriately and interact positively with their families and with other adults and children, parenting becomes less stressful.” (from http://www.strengtheningfamiliesillinois.org/index.php/main/content/protective_factor_5/).

#6: “When parents have healthy relationships with their children, they are “in tune” with them: they can listen to their children, understand them, and perceive their needs. A parent who fully comprehends and accepts the role of parent serves as the child’s chief provider, protector, and teacher; shows love for the child; and strives to meet the child’s needs and provide a solid foundation for life. Through this relationship, children can trust, learn, grow, and explore the world.” (from http://www.strengtheningfamiliesillinois.org/index.php/main/content/protective_factor_6/).

Discussion points:

- How do you see these protective factors in your life? Which do you relate strongest to?
- How can you build some of these and which ones would you pick to build upon?
- How can we better help you meet these needs?

Closure:

Depending on time left in the session, the facilitator could ask the group:
• How did that go for everyone?
• What was useful about the session? What did you find not as useful?
• What would you like to see more of?
• What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

Next week’s topic is: Importance of the parental/caregiver relationships and positive relationships.

Optional activities:

View Nadine Burke Harris video from:


It provides a great explanation of how effects from childhood trauma can affect us as adults, and explains ACEs well. The video also notes how children can often be misdiagnosed with ADHD, and may really be suffering from the effects of trauma.
Activity:

Try 2 or 3 exercises from the Living Protective Factors booklet (see [http://www.strengtheningfamiliesillinois.org/mirror/downloads/LPF_6_Web.pdf](http://www.strengtheningfamiliesillinois.org/mirror/downloads/LPF_6_Web.pdf)). I like the breathing one on p. 36, which could also work for the self-regulation session (give bullets for this one). The question/reflection writing exercise on p. 28 is also inspiring. P. 71 great questions for thinking from the perspective of your child, and relating to her.

Discussion points:

What do you think of these exercises? (Try some of these in class, maybe break into small groups, or altogether)

Activity:

Parents can do ACES test here: [http://aces toohigh.com/got-your-ace-score/](http://aces toohigh.com/got-your-ace-score/)

Activity:

For older youth (potentially clients as well, where applicable, 15 to 24 years old), visit or print handout from:


Links to several parenting resources, Be Strong Families (from Rebecca Lowry):

[http://www.strengtheningfamiliesillinois.org/index.php/main/content/category/for_parents](http://www.strengtheningfamiliesillinois.org/index.php/main/content/category/for_parents)
And more generally:

http://www.strengtheningfamiliesillinois.org/index.php/main/content/category/links

Real-time updated resources for both parents and staff, http://www.bestrongfamilies.net/

The importance of relying on other parents/adults for support in raising children:


A good link with more resources for parents and also about building community resilience (can order through the site), links resilience and protective factors well:

http://nctsn.org/content/protective-factors-enhancing-resilience-young-children-and-families
**Week 6: Importance of the parental/caregiver relationships and positive relationships**

*Desired outcome:* You will have a greater understanding of the importance of the parental/caregiver relationship and other positive relationships for your child in healing from the effects of trauma.

*Notes to facilitator:* This week’s session is heavy on psycho-education and less focused on activities. The first activity revolves around an excerpt form a video in week 1, but is highly relevant to the idea that parental relationships and relationships in general are critical elements of healing from trauma.

*Day at a glance:*

Activity 1: View video (first 6 minutes only) and discuss (25 mins.)

Activity 2: Powerpoint, handout, read-write exercise, and discussion (25 min)

*Detailed activity plan:*

Today, we will watch some video about the importance of relationship in healing trauma, and then have some discussion about that. We will also explore some of the literature/research about the importance of relationship.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust.…”

Check-in about any thoughts about the video viewed last week.

*Activity 1 (Video, Trauma, Brain & Relationship: Helping Children Heal (video), and discussion,* [https://www.youtube.com/watch?v=jYyEEMlMMb0](https://www.youtube.com/watch?v=jYyEEMlMMb0)
Discussion points:

- What feelings is this bringing up for people?
- The facilitator can emphasize the importance of relationships in healing
- Basic message simple, being present, kind, sensitive, and patient

Activity 2 (View a few powerpoint slides and handouts, and discuss in depth)

Present MS Powerpoint slide (see slide content below).

**Importance of Relationships in Healing Trauma**

- One caring adult can have a large impact (Masten & Reed, 2002)
- Relationships are critical for bringing about changes in the brain (Perry, 2013)
- Those with a greater number of positive relationships tend to have greater resilience (Perry, 2013)
- Andrade link (48:25 to 49:15), [http://www.youtube.com/watch?v=i7fSdiLlb](http://www.youtube.com/watch?v=i7fSdiLlb)

Handout (include the following):

Child needs a “therapeutic web” of caring adults to provide the relational environment needed for proper development (Perry, 2006, p. 44).

Key Implication of Perry’s #6, “The human brain is designed for a different world.”. Perry (2006, p. 44): “Increasing the number and quality of relational interactions by bringing more healthy adults into the lives of these children and their parents is a key
element of home visitation models, mentoring programs, and after-school programs. The more developmentally delayed the children are, the more desperately they need relational interactions; how often have we heard that a difficult child in a preschool group does just fine one on one? This child is 5, but actually requires the relational richness of the 1:1 interaction typically reserved for infants. A neglected, maltreated child is all too often an infant emotionally. If given this relational attention for a sufficient length of time, the child will begin to “develop” (i.e., to resume a more typical developmental trajectory), and over time will no longer require this level of relational attention. Unfortunately, our systems are rarely capable of providing this level of reparative interaction.”

Perry (2006, p. 44-45): “We humans have not always lived the way we do now. Human beings are biological creatures. Of the 250,000 years or so that our species has been on the planet, we spent 245,000 years living in small transgenerational hunter-gatherer bands of 40-50 individuals. The human brain has evolve specific capabilities that are hominid and prehominid adaptations to millions of years of living in the natural world in these transgenerational groups. One of the most important features of this natural world was the relational milieu. We lived in a far richer relational environment in the natural world. For each child under the age of 6, there were four developmentally more mature persons who could protect, educate, enrich, and nurture the developing child—a ratio of 4:1. In contrast, the modern world is defining a caregiver-to-child ratio of 1:4 as a “best-practice ratio for young children (1/16th the relational ratio the human brain is designed for). Our children also spend many hours each day watching television; they spend very few hours in the socioemotinal learning opportunities created by interactions with older children,
younger children, aunts, uncles, nephews, grandparents, or neighbors. In contrast to our ancestors, we live in a relationally impoverished world.”

Discussion (Read-write exercise, then come together and discuss as a group):

- What do you think about what Perry says?
- Can you think of ways to help increase the number of quality relationships your child has in her life? Is this possible for you? Why or why not?
- Is there any way we could help you with doing this? (What are some of the barriers? How can we as staff help remove these, or be someone that you can trust more?)

Closure:

Ending, Discussion points:

- Parents probably already have some elements of this (positive relationships) in place. Where do you find hope in your relationships with your children?
- How might you build upon some of these positive elements?
- Where are you taxed and how do you see some of the protective factors possibly helping?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

Next week’s topic is: Attachment.
Optional Activities:


Chapter 4: “2. Discuss and detail the therapeutic style of Mama P. Find at least five key ingredients of her intimate and effective work with Virginia and Laura. Then draw as many parallels as possible how school staff members could combine to provide Mama P. style therapy for troubled students while they are in school.”

Discussion points:

- The importance of safe touch, p. 95 (middle) to 97 (end), touching passage about how Mama P. helped teach a mother about affectionate interactions with her child.
- Develop trusting relationships, creating sense of safety (http://www.youtube.com/watch?v=g3cz-QIPkOo, Perry)


Chapter 3: “3. On p. 80, Dr. Perry says, ‘In fact, the research on the most effective treatments to help child trauma victims might be accurately summed up this way: what works best is anything that increases the quality and number of relationships in the child’s life.’ What is your staff doing now or what can your staff be doing in the future to increase the quality and number of relationships in a student’s life? Record some practical steps to making sure this happens at your school.”

I think presenting this question to parents can have some interesting effects, one that it is partly the school’s responsibility to help provide these relationships for their children,
and that they can advocate for their child to receive these services, and two, that relationships are important.

CSEFL worksheets, link (a lot of this is actually good for the emotion coaching session):

http://csefel.vanderbilt.edu/resources/family.html

[Note local resource for parents: Nurse Family Partnership, for first-time moms.]

Consider handout containing some of the following points from the MS Powerpoint slide above:

- One caring adult can have a large impact (Masten & Reed, 2002)
- Relationships are critical for bringing about changes in the brain (Perry, 2013)
- Those with a greater number of positive relationships tend to have greater resilience (Perry, 2013)
- Andrade link (48:25 to 49:15), http://www.youtube.com/watch?v=i7ftSDiILbI (Really validates the importance of caring adults in a child’s life, though needs to be carefully framed; it would be easy for a parent to think that you were saying that they aren’t caring).

Consider refresher on protective factors, depending on whether parents had been present for the previous session (see Week 5).
**Week 7: Attachment**

*Desired outcome:* You will have a greater understanding about the importance of attachment and have a greater ability to foster attachment with your child.

*Notes to facilitator:* There is only one activity, and it involves several videos about attachment from Kids in the House (2015), [http://www.kidsinthehouse.com/home3](http://www.kidsinthehouse.com/home3), a really great resource for parenting. These videos might be triggering of guilt and shame for many parents, particularly of older children, if there was not a strong attachment bond. It will be important to comfort parents that there is no judgment about this, but that it is more about their awareness of how that might affect their child.

There are also some interesting optional activities for this, including a few references to Theraplay techniques. There are also a few videos listed below that would be relevant to parents of infants and newborns.

*Day at a glance:*

**Activity 1:** Videos and discussion (30 min.)

**Activity 2:** Handout and discussion regarding practical tips (20 min.)

*Detailed activity plan:*

Today, we are going to watch several short videos about attachment, and have some discussion between the videos. There will also be a handout with a few tips about attachment.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust….”
Check-in about any thoughts from last week on relationships, anything that parents may have tried.

Activity 1 (Educational videos about attachment)


And/or Brain development, dependence on adult caregiver, patterns, relational experiences shaping a pathway for relating to others, and expectations of how they are related to and treated: [http://www.kidsinthehouse.com/baby/bonding-and-communication/attachment-parenting/the-science-behind-attachment-parenting](http://www.kidsinthehouse.com/baby/bonding-and-communication/attachment-parenting/the-science-behind-attachment-parenting)

Discussion points:

- What do you think of those first videos? Do they make sense to you?
- What about it do you relate to? What maybe doesn’t fit as well for you?

Child wanting to be liked, belonging/loyalty/obedience, importance, intimacy (3 mins): [http://www.kidsinthehouse.com/preschooler/communication/developing-good-attachment](http://www.kidsinthehouse.com/preschooler/communication/developing-good-attachment)

Discussion points:

- What did you think about his ideas?
- Have you seen these developments occurring in your child’s life? Do you have the level of connection with your child that you would like? (We understand that these videos can stir emotions about things that maybe can’t be changed, but it’s not too late to develop this; it’s going to take some effort, but there is hope.)
Increasing feelings of attachment (put down cell phone, read a book together):

http://www.kidsinthehouse.com/elementary/communication/bonding-with-five-to-seven-year-olds/increasing-feelings-of-attachment#.Ul3VXTPXn-o.email

Discussion points:

• Anyone have any thoughts about this?
• Does that seem like something that is possible in your life today? Why or why not?


Discussion points:

• What did you think about the self-reflection piece? (If interested, we are available for further discussion individually, or as a group)
• Did that offer hope for anyone?
• What did that spur in your thought process or as an emotional reaction?

3-4 final talking points about attachment:

• The idea of attachment experiences forming a template for all of our relationships, creating a sense of safety (Perry, 2001)
• Children having difficulty with attachment may isolate, and have some difficulty trusting, and making friends (Perry, 2002)
• Our ability to feel safe with other people
• Our belief about whether our needs will be met, and whether it’s ok to ask for these needs to be met
• Some of us have maybe never had the type of attachment that the videos talk about. How does it feel to watch these videos?
• Does your child feel safe in the world, and do they believe that their needs will be met?

Discussion: do you see examples of what the video was talking about in your own family?
Activity 2 (consider as handout)

Some practical tips:

Consistency, repetition, and predictability are important (Perry, 2001). Safe, positive physical contact, such as hugging, holding, feeding, rocking, singing, laughing are important for helping promote bonding and attachment (Perry, 2001).

If you notice your child having a hard time, make some time to sit and talk about what is upsetting your child and thank them for sharing their thoughts and feelings with you.

Tips for helping a child who is having difficulty with attachment (adapted from Perry, 2002):

- Use eye contact, listen closely, and give positive touch; pay close attention.
- Use humor, but be careful not to criticize sarcastically.
- Ask your child, “What makes a good friend? What qualities do you see in yourself? What do you see in others?”

Closure:

Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how
Next week’s topic is: Self-regulation

Optional Activities:

If more focused on infants, these three short videos (about 1 min each) are helpful:

http://www.kidsinthehouse.com/baby/bonding-and-communication/bonding-with-your-
newborn/importance-of-forming-an-attachment-bond

http://www.kidsinthehouse.com/baby/bonding-and-communication/bonding-with-your-
newborn/forming-secure-attachment

http://www.kidsinthehouse.com/baby/bonding-and-communication/attachment-
parenting/how-to-form-a-healthy-attachment-to-your-baby

http://www.kidsinthehouse.com/baby/bonding-and-communication/attachment-
parenting/how-our-own-childhood-impacts-our-parenting

Handout (with material below):

Attachment therapy games (Theraplay example from a parent):

https://www.youtube.com/watch?v=QmQbtMQfMck

Practice some of these games from the list below. Handout to clients and practice a few
of these activities, when partnered up. Facilitator can choose a handful of activities to
practice or clients can choose their own, and ask the facilitator questions.

Short List of Theraplay Activities by Dimension, extracted from Rumley (2008); original
source of activities was Jernberg & Booth (1999), pp. 393-405:
“Structure

Bean Bag Game. Place beanbag or soft toy on your own head, give a signal and drop the beanbag into child’s hands by tilting your head toward the child. Take turns.

Peanut Butter and Jelly. Say “peanut butter” and have child say “jelly” in just the same way.

Repeat five to ten times, varying loudness and intonation.

Red Light, Green Light. Ask child to do something, for example, run, jump, move arms. Green light means go, read light means stop. For a more challenging version, stand across the room facing away from the other participants. When you say “green light,” the child and parents or co-therapist creep toward you as quietly as they can. When you say “red light,” turn quickly to see whether anyone is still moving. Anyone caught moving must return to the beginning. The goal is to creep up and touch the person whose back is turned.

Engagement

Blowing Over. Sit facing the child and holding hands (or cradle the child in your lap), have child “blow you over.” Fall back as the child blows. Once child understands the game, you can blow her over.

Peek-A-Boo. Hold child’s hands (or feet) up together in front of your face. Peek around or separate hands (or feet) to “find” the child.

Sticky nose. Put a colorful sticker on your nose. Ask child to take it off. Or stick a cotton ball on your nose with lotion. Have child blow it off.

Nurture
Caring for Hurts. Check hands, feet, face, and so forth, for scratches, bruises, hurts, or “booboos.”

Put lotion on or around hurt, touch with cotton ball, or blow a kiss. Check for healing in the next session.

Decorate Child. Make rings, necklaces, bracelets with play-doh, crazy foam, crepe-paper streamers, or aluminum foil.

Feeding. Have a small snack and drink available for all sessions. Take the child on your lap or face her as she sits propped on pillows. Feed the child, listening for crunches, noticing whether the child likes the snack and when the child is ready for more.

Encourage eye contact.

Challenge

Balloon Tennis. Keep balloon in air by using specific body parts: heads, hands, no hands, shoulders, and so forth. If you choose feet, everyone lies on the floor and keeps the balloon in the air by kicking it gently.

Partner Pull-Up. Sit on the floor holding hands and facing each other with toes together. On a signal, pull each other up to a standing position.

Pillow Push. Place a large pillow between you and the child. Have child push against pillow to try to push you over.”

Link to Theraplay book, lots of activities as well as the theories behind Theraplay:

http://file.zums.ac.ir/ebook/268-
Link to Activities that are useful (See App. B for Theraplay list of activities above, and also Marchak interaction activities):

http://krex.k-state.edu/dspace/bitstream/handle/2097/734/NancyRumley2008.pdf?sequence=1

Video about the attachment and addiction link (Dr. Mate):

https://www.youtube.com/watch?v=daPr02A7i2A

For parents with children with Reactive Attachment Disorder (RAD), a good resource with tips:


More resources on attachment, and promoting secure attachment (may be a useful handout), from CSEFL (n.d.), see http://csefel.vanderbilt.edu/resources/wwb/wwb24.html:

“To foster a secure relationship with the child:

• Be warm, responsive, and affectionate with all children. Caregivers and teachers’ affection helps children feel worthwhile and teaches them how to show affection.

Reading and responding to cues given by children is critical (e.g., smiling or reaching to
indicate they want to interact, pulling away or arching their back to indicate they need a
break from the interaction, or showing sadness or distress).

• Engage in meaningful conversational interactions with children. Reciprocity, taking
turns in interactions, helps young children feel competent.

• Be physically and emotionally available when a mobile infant or toddler explores
his/her environment. Mobile infants and toddlers explore their environment and return to
their special adults when they need a hug, a pat, or encouragement. Toddlers balance
closeness to an adult and exploration; they focus on accomplishing tasks, yet will seek
adult help when they need it.

• Comfort children when they are distressed. Infants and toddlers learn to organize and
manage their emotions when adults consistently respond to their communication cues and
comfort them when they are distressed. When children feel insecure, stressed, or have
experienced trauma, neglect, abuse, or maltreatment, teachers and caregivers need to
provide consistent emotional support to help children feel safe and to help them trust
adults again.

• Be an enthusiastic learning partner. When adults are unintrusive, follow a child’s lead
during play, and provide help that supports problem-solving, the child’s confidence and
motivation to learn grows. Share a child’s excitement about learning and remember that
each moment during the day has the potential for relationship building.

• Let children know that you will provide safe behavior boundaries, keeping them, their
peers, and their things safe. Adults who demonstrate and teach infants and toddlers how
to behave in a social way by example, rather than telling children what not to do, are not
only keeping children safe, but also teaching them how to behave with others. For example, showing a child how to touch a peer gently instead of simply telling them to stop demonstrates the suitable behavior.

• Provide small groups, low adult-child ratios, and primary care. An environment that allows for consistency in personnel, substantial time, and adequate space to build 1:1 relationships is a key ingredient in forming strong, healthy attachments between children and adults.

• Move caregivers and teachers with a group of children to a new room as children develop. Consistency is critical for infants and toddlers as they transition to new environments. Allowing for a way to let adults move with some of the children to a new environment (infant care to a toddler classroom) will help children feel secure as they face changes and new challenges in the environment.

• Develop program policies to refer families who need additional mental health support to the right resources. Families who experience stress need ongoing social support, so that they can be warm, responsive, and affectionate with their children. Programs can help by providing families information and access to materials and other resources. Programs can also serve as a bridge between families and services available in their communities.”

(Extracted from http://csefel.vanderbilt.edu/resources/wwb/wwb24.html).
**Week 8: Self-regulation**

*Desired outcome:* You will have a greater understanding about the importance of self-regulation, and how practicing it could look for you and your child. You will also have an opportunity to practice these skills either during session or between sessions.

*Notes to facilitator:* What I have as the primary activity involves primarily education and discussion. There are also some useful activities in the Optional Activities. I like the breathing activity from the TFCBT website, particularly since it involves suggestions on having children re-teach the breathing to their parents. However, you may already have breathing exercises that you like to use. This is a great opportunity to practice mindfulness, and becoming aware of the breath and body as tools for self-regulation.

I also really like the Flipping Your Lid analogy from Daniel Siegel, as well as the Zones of Regulation. They seem to be really useful, practical tools that can be used relatively easily with children. These could be provided to parents as a handout for when things get challenging, with some discussion and explanation during session.

There is also a great video that is long, but has some great parts to it (see [https://www.youtube.com/watch?v=B7C9Cs6_DH8](https://www.youtube.com/watch?v=B7C9Cs6_DH8)). Talks about co-regulation with parents, then learning how to self-regulate, at about 21:00.

*Day at a glance:*

Activity 1: Video and discussion (35 min)

Activity 2: Breathing exercise (15 min)

*Detailed activity plan:*
Today, we are going to watch a few videos about self-regulation, and we’ll also have an opportunity to practice self-regulation. The reason why we’ll be watching these is to get an appreciation for why self-regulation is important and what can be done to help improve our child’s ability to self-regulate.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust….”

Check-in about any thoughts about the video viewed last week.

Activity 1 (Video and discussion)

View Regelena Melrose video, http://www.youtube.com/watch?v=rzm0t6wXW0c

[6:10 to 10:00] (Self-regulation modulates arousal level, and allows us to use our neocortex).

What is it? Our ability to modulate arousal levels, or anxiety, etc.]

Discussion points:

- What did you think about the emphasis on sensation rather than words for younger children?
- Have you noticed any issues with your child in self-regulating (i.e., more reactive)? What have you noticed?
- Are there specific times or situations when your children have a difficult time self-regulating?

And video on “Connecting your body and developing your intuition” (heart message, belly message, breathing), (Kids in the House, 2015),

Discussion points:

- Does anybody try this at home? Do you notice any feelings in your body right now?

[0:00 to 4:10]. Regena Melrose, see https://www.youtube.com/watch?v=JhBiC6hGszk

- How many of you struggle with self-regulation for your own lives? (These activities may help you as well as your child).
- What do you think about putting yourself first? How does that feel? Do you agree with Regelena Melrose? (It’s difficult to keep a child isolated from distress when you are distressed yourself. We’re going to try an exercise to help with that).
- What do you think would help you feel more balanced?

Activity 2: Practice breathing with the group, people can partner up and try the activity that follows.

(Nota facilitator: if you have your own methods already for this, the facilitator can do whatever they are most comfortable.)

The following was adapted from the Medical University of South Carolina (MUSC, 2005), (see http://tfcbt.musc.edu/modules/breathing/introduction.php):

Intro: We are going to work on breathing today to help with being upset or scared. If you can learn how to control the breath, it will help you to calm down. (Can lower anxiety, provide some control over emotions and the body)

Position: You can sit with the back straight in your chair (like me), and put one hand on the stomach (above belly button) and one on the chest.

Technique: When breathing in, the hand on your stomach will move; the hand on the chest will not. Try to breathe more slowly on the out-breath than the in-breath.

Relaxing word: Continue breathing as such, but breathing out, I would like you to say to yourself, “calm”. If you have other thoughts, I would like you to imagine them floating away like clouds in the sky.

Child to demonstrate: Show an adult how to do it. Explain it to them.
Homework is for the child to do 10-minute sessions twice a day.

Handout:

Tips for helping a child who is having difficulty with self-regulation (adapted from Perry, 2002):

- Quickly intervene and stop any hurtful language or action
- Model self-control during difficult situations
- Praise positive actions and problem-solving skills

Tips for what you can try at home, if you are interested (adapted from Perry, 2002):

- Try to work a “breather” into your daily routine, or as necessary when you notice your child getting agitated. Sit them down, dim the lights, and have them take some deep breaths. Ask them to listen to their breath during their inhale and exhale. You can name different body parts (arms, shoulders, face, neck, legs, toes), and have them continue to breathe, relaxing each body part. A quiet activity (like coloring) can follow the breather.

Closure:

Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how
long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

Next week’s topic is: Helping children process difficult emotions and being present for children

Optional Activities:

“Flipping your lid”, see https://www.youtube.com/watch?v=DD-lfP1FBFk for the hand model of the brain presented by Daniel Siegel (NeuroLeadership, 2010), great simple explanation.

And also this link provides a possible handout for class:


Zones of Regulation, which can be used to help children become more aware of their emotions and how to better manage them:

http://www.zonesofregulation.com/

Regena Melrose, https://www.youtube.com/watch?v=JhBiC6hGszk

Same video as above, but the optional part is the segment from [8:55 to 14:59]; explores night terrors, nightmares, that can occur after surgical procedures. She talks about how a child can’t fight and can’t flee in these situations. She also explains how trauma affects the ability to self-regulate.
Regena Melrose gives a nice, simple explanation of why it’s important to be in the zone of optimum arousal (~6:00) for learning, and that self-regulation is key for being in that zone. The place of normal challenges, and how extraordinary events (like trauma) affect the ability to self-regulate.

https://www.youtube.com/watch?v=9Pemu0V5LiU

The Living Factors (Wolf, 2012) book addresses:
Self-care (See reflection questions on p. 46 for taking care of your body)
Possible Handouts: [Self-regulation] Taking care of yourself (Part 1, addresses protective factors 1, 2, and 4), great activity on p. 36 about following your breath.

Self-care video, a good one here (Gabor Mate, specifically for caregivers):
https://www.youtube.com/watch?v=c6IL8WVyMMs

For parents with tweens that are getting moody:

Some good information here as well, about self-regulation strategies for parents, beginning at about 21:00, co-regulation with caregivers, etc.:
https://www.youtube.com/watch?v=B7C9Cs6_DH8
Week 9: Emotion coaching (Helping children process difficult emotions and being present for children)

*Desired outcome:* You will be able to be present for your child and have tools to help them process difficult emotions.

*Notes to facilitator:* I love Peter Levine’s stuff, as you can see by the copious amounts of his material. I also really love the video clip from “Kind-Hearted Woman.” All the material presented in this section could easily be two sessions (see optional activities); you may want to ask the group if they are interested in exploring the subject more in the next session, at the end of this week’s session.

*Day at a glance:* Summarize what the activities are, outline

- Activity 1 (15 mins), Show and discuss video explaining what emotion coaching is.
- Activity 2 (15 mins), Show and discuss video providing real-life example of emotion coaching
- Activity 3 (20 mins), Role play activity in pairs

*Detailed activity plan:*

Today, we are going to talk about emotion coaching. First, we’re going to show a video that discusses what that is, and have some discussion about it. Then we’re going to look at an example of emotion coaching in real life, and discuss some more. Finally, we’ll have an activity where we’ll get a chance to practice emotion-coaching, with some follow-up discussion on how that went.
[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust….”

Check-in. Did anyone try anything different with their child based on last week? How did that go? What did that feel like for you? For your child?

**Activity 1** (Explaining what emotion coaching is).


[Main video points (Labeling and validating how feeling (through some empathy); all feelings ok, though not all behavior is ok, i.e., “ok to feel angry, but not ok to hit your sister”; message is that we can find ways to cope with feelings without the negative behavior.]

Discussion points:

- Do you do some of this with your child?
- What did you find useful about her suggestions?
- How critical do you think repetition and consistency is?

**Activity 2** (Emotion coaching real-life example).


Discussion points:

- What did you like about what the mother did?
- What did you notice about how the child’s attitude changed?
- Do you see anything similar in what you do? Was there anything she did that you would like to do with your child?
• [Note that the mother stayed calm through the interaction.
  • Narration without punishment, builds executive functioning.]

**Activity 3 (Role-play)**

Role-play emotion coaching. Divide into pairs, and pick a common emotional scenario that is problematic for your child and you. One person will be the child, and the other person will be the parent.

**Discussion points:**

- Conflict is how we learn (Breathing/walking to calm; honoring children’s solutions, even if silly).

**Closure:**

Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

Next week’s topic is: Positive Discipline.
Optional Activities:

Provide hand-outs (as appropriate to the track being played):

Slinky example for somatic experiencing: resetting the nervous system little by little, by releasing the energy and integrating it back into the body a little at a time.

https://www.youtube.com/watch?v=ByalBx85iC8

Emotional first aid (The following material is adapted from Levine (2004), and includes many direct quotes.)

Track 5 of Levine (2004), [“How to initially respond to trauma”, Emotional first aid, 7:15]

How to apply this knowledge to your children in aftermath.

Two practical steps with infants and small children:

By two years old, many falls (some subtle signs but not obvious).

Give ourselves the first aid first (oxygen mask example), because children are really attuned to adult’s emotions like anger or fear, very sensitive to these emotions. Their very survival depends on their ability to pick up signals about their caregivers, and they can be even more affected by adults’ reactions than that of an event itself. It is normal for you to feel angry or shocked, and a common reaction is to get angry with the child and scold the child. Common reaction.

Best thing to do is to not react this way, and that is by taking care of yourself first. It can complicate the feelings your child has, and possibly re-traumatize the child. If you can stay centered, calm, and accepting, that is best. You may need to take a moment to allow
sensations to calm, things like feeling the feet, and being present in your body (unless an emergency situation).

Then, you may be able to pick up a child, but the child needs some time often to settle before being ready for that. If you are still tense, you may make the child more tense as well. Feel your own feelings first, then when you are calm, pick up slowly, and may want to rock them gently. (Follow your natural parental instincts; trust your instincts.)

Validate child’s physical reactions; they will tremble and cry at first. “Resist the urge” to stop them for a minute or two. Let them know it is ok, normal to react this way. Studies show that this response, if allowed, can help prevent further issues.

An older child may not want to be held, but gentle touch can be helpful. Touch gently in a safe place, shoulder/ upper back for instance. Don’t want to distract, but also want to be close to help inspire a sense of safety and support.

Track 6 of Levine (2004) [“Attending to your child’s experience”, 6:57]

“Attending to child’s mental and emotional experiences”

Talking about the experience or their feelings might be helpful.

Can ask them what they might be feeling, or if they are feeling mad, sad, or scared?

If they froze during the experience, can run in place say if they felt like running but couldn’t. Purpose not to run or get too much into the running itself, but to allow the energy to come out slowly (like the slinky example).

(If child injured, try the calming part only. Come back to emotions later.)

Trauma response is a natural process.
Don’t worry about doing it perfectly; trust your parental instincts.

Play (2:19 to ~4:00) for example.

Example; shaking and crying 4 y/o child. “It’s ok; you’re shaking and trembling just like the leaves on the tree.” Completing the process of the natural trauma response. Listen, let know ok, not their fault. It doesn’t require complex therapy. (Will ask certain questions later.) Your presence is the most important thing.

They may engage in play, and still be working with processing the experience. Can just observe this. Let the child lead. Empathize and support them in this; concrete example, bad concrete.

Getting them back on the horse, but not too soon. Falling off the bike example. Child wants to master the task. Parent can give them a little bit of support in this, can help them get through this fear. After calmed, and talked about feelings, can suggest/ask how about I help you with the bicycle again?

Track 9 of Levine (2004) [“Helping your child process trauma”, 5:26]

If the child is still bringing up the event, may need to explore that further. Help with communication about feelings and details of the events.

Simple tools:

[May want to try playing this entire track if the group is willing and attentive; really great practical tips.]
Not to relive the event, but to support them so they can process “parts of the experience that were overwhelming” and the feelings that they couldn’t handle before. (gaining mastery over feelings and situations.)

Bodily sensations, story, and play are child’s language.

Key is sensation, “language of reptilian brain”, which “encodes the trauma response.”

[“Address through sensation-based languaging.”]

In creativity, they will bring up the “parts that still need resolution”.

When child says they are having a feeling, ask where they feel that in their body (ask them to point to it). If they don’t know, can ask, “Do you feel it in your head? Do you feel it your arms, etc.?” (Point to these places when you ask.)

[3:00 to 4:27] Sensation (heat), or an image (“hard like a rock”). When you feel a sensation that’s hard like a rock, “Does it have a shape? Does it have a color? Do you feel it more or do you see it more?” There can be flow between sensations and images for children.

Main idea: It’s about moving the internal experience along (“trauma is about being stuck, and flow is what happens when we come out of trauma”, with sensations, pictures, play, etc., it will “help the child integrate the experience.” [Getting unstuck]. [“Drawing, stories, and play”]

[4:27 to end] Introducing reminders that may still be overwhelming, gradually, the car seat example from the accident scene. Take baby steps. If they have a reaction (e.g., holding breath, stiffening, or heart rate changes), work on supporting your child using the methods expressed earlier (simply being present, validating, holding, rocking, etc.).
Track 10 of Levine (2004) [“Creative Ways to Express Emotion”, 9:01]

Not too much discharging of energy at once. Examples: Play with toy cars showing crash. Playdo helps with sensation of molding; shaping dough to represent what they feel. Check in to see how they feel with emotions and sensations, leading to a release. Same with artwork, describing sensations as they share drawings or sculptures. “Sense and discharge trauma energy.”

Picture example: Direct talking doesn’t always work. Go to positive parts of picture. “Hmm, I like that tree. When you see that tree, can you show me where….” (Shifting between sensation and image). Can gradually move towards more negative part of the drawing, i.e., cars crashing, etc. “When you see this part of the picture, where do you feel that inside?” Can also shift back and forth between different parts of the picture, and their associated sensations. Can transform the child’s experience. (~3:00 to ……), nice description of kids’ creativity and following that creativity. “Internal, self-regulatory process that takes them towards equilibrium, and that process is mediated, is governed, through their creative expression, through the sensations, through the pictures, through how the sensations and the pictures dance together. And so, as you help them connect to that creative process, that act in itself is healing.”

Diminish repetitive behaviors.

Another thing you can do with child: If avoiding, say, write a story before you tell it to them, that has your memory of how something happened. If they become fidgety, pause, reassure the child (“it’s ok. it’s ok that you feel that. Can you show me where you feel
that feeling right now?”). Whenever they have a reaction, Guide them through like before, shifting between feelings, sensations, and images. Idea: “Tell a suggestive story that describes the experience as you believe it happened…to a generic child.” Child can identify with the character in the story rather than re-living it. Can co-create a new story, with “new elements of the experience”, “evoking creativity” with creative images and bodily sensation to better integrate the experience.

If it’s too much for the child to do the above, physical activity like clapping could help. Could be used when child is having sleep problems. Sit quietly with the child, put on wrist or shoulder. “It’s ok. You just had a bad dream. Do you remember any of the pictures in the dream?” Can you tell me where in your body you’re feeling the feeling?” “Can you show me now?” Go through body response, and any images they remember, not exact of the event, but part of “child’s creative self-healing process”.

“It’s important to note that shifting and deepening awareness of inner sensation and images takes time. Doing too much, too fast can prevent the maximal integration, can even frighten the child.” Need to go slowly enough to prevent further upset. Practice and patience.

Later exercise (Track 12) will help with your own “felt experience” and rhythm with that.

Track 12 [“A sensation-awareness exercise”, 9:10]

Note to facilitator: This exercise is for the parent; if there’s interest in the previous Levine materials, you can try this track as an activity. The question of “Where do you
feel it in your body?” could be a good one for parents, particularly if they are challenged in being present and in their bodies.

Notice where your body is touching the seat, how the chair supports your back.

Track 13 [“Moving through stuck sensations”, 3:35]
This track explains the reason for the exercise in Track 12. [Note to facilitator: I think that this is a great wrap-up exercise to confirm what’s been learned in previous tracks.]
Getting acquainted with different feelings that arise during different situations (i.e., dread, conflict, surprise, happiness). Nervousness activated in different ways. There is a “sequence of sensations.” That will help you move through to a calm, more centered place, where you can help your child without scaring them and being most effective in helping being supportive to them.
Getting yourself unstuck in emotions, to a more calm, more centered place, where you can help your child without scaring them and being most effective in helping being supportive to them. (transitioning from dread to surprise to happiness)
Possible Activity:
[1:20 to 3:34], Exercise: Come home, children running around house. Falling down stairs, sobbing hysterically. Feel shock first, (“where do you feel it?”), exploring sensations.
Take one or two moments now, practicing for when your child is injured or hurt.
“Register and move through.” Taking them into your arms, one or two words to orient to you, being present.
Register your own feelings.
Holding, rocking

One or two words that orient them to you and also lets them know that it won’t last forever.

Not alone, processing shock reactions through feelings and sensations in their bodies.

Discussion:

- What was that experience like for you? Anyone care to share what feelings came up, and where in the body that they were experiencing the feelings?
- What was hardest for you? What came naturally?
- What was helpful about this exercise/technique for you?

A few key points based on Levine (2004) overall:

- The idea that the emotion moves through with some help; trauma is about being stuck.
- Getting the feeling to move through rhyme, play, imagery, and sensation.
- Apply the emotional first aid to yourself first (breathing), then apply to your child.
- Acknowledge the feeling, then ask your child “where do you feel it in your body?” Asking these types of questions shifts from sensation to imagery and feelings, and helps process the trauma, moving it through the body.
- Being present and helping your child process the trauma requires some patience, but it doesn’t require perfection.
- “Trauma is a fact of life, but it doesn’t have to be a life sentence.” (Levine, 2004)

Activity:

Role play with a partner, with one being the child. Listen to Track 11 (4 y/o Timothy, near-drowning example).

Note to facilitator: Track 11 might be a good one to play, relevant to our local environment, ocean, beach, etc.
Discussion points:

- What did she do that might come naturally to you?
- What did the mother do that might be challenging for you? Why is that?

(Note to facilitator: Consider also the Track 12 Sensory Awareness Exercise, and Track 13 short exercise imagining your child falling and getting injured on the stairs.)

Alternate activities/Hand-out:

More on somatic experiencing here, at Peter Levine’s site:


Regena Melrose (sensory awareness),

https://www.youtube.com/watch?v=Rl2EXVIWneM

And the value of staying physically close to your child after an event:

https://www.youtube.com/watch?v=FiWNveFfJ1I

https://www.youtube.com/watch?v=cmsyNxag6fc

(Dr. Peter Levine clip on helping children who experience trauma)

Teaching how to mirror emotions with babies:

Reading behavioral cues when children are non-verbal (trying to understand, being curious):


CSEFL worksheets, link:

http://csefel.vanderbilt.edu/resources/family.html
**Week 10: Positive Discipline**

**Desired outcome:** You will understand the ideas behind positive discipline, and be able to utilize tools of positive discipline with your child.

**Notes to facilitator:** There is so much good material on this topic that it was difficult to choose. The first video is educational and describes what positive discipline is. It’s not the most exciting video, though it provides a great concise description about what positive discipline is, from one of the original authors behind positive discipline.

I ended up centering activities around Daniel Siegel’s ideas regarding “Flipping Your Lid” (an easy way to understand the brain an also connects well with our other materials that focus on the brain), but if this does not resonate well with your group, there are many alternatives. The Optional Activities have some really great video links, including one from Brian Post, whose style is really engaging and easy to follow, explaining problematic behavior and how to relate to a child that is exhibiting these behaviors.

You may want to check in with the group to see if there is interest in a second class on positive discipline. If there is interest from the group, there could be an additional session focusing on the praise and logical consequences videos that are provided in the Optional Activities. I’ve also provided a few links to what can be really good handouts for parents in the Optional Activities regarding positive discipline tips.

**Final note:** For planning for next week, it might be a good idea to provide a handout of possible activities (see next session for handout) that parents might want to try next week,
and to have them choose before they leave today. That way, you can prepare your
materials if they are needed for the activities.

Day at a glance:
Activity 1 (10 min): Short video (Define and discuss what positive discipline means)

Activity 2 (30 min): View video on Flipping your Lid from Siegel, provide handout on
parenting around flipped lids, and discuss what this means for parents

Activity 3 (10 min): Role play positive discipline.

Detailed activity plan:

Today, we are going to talk about positive discipline. First, we’re going to show a few
videos that discuss what that is, and have some discussion about it. Then we’re going to
have an activity where we’ll get to practice positive discipline.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For
example, “These are the rules we established to provide an atmosphere of safety and
trust….”

Check-in. Did anyone have any thoughts about emotional first aid from last week, and
did anyone have the opportunity to try any of those techniques last week? If not, ask if
there were any situations where it could have been useful or may be useful in the future.

Activity 1 (Discuss definition)

Watch brief 3-min. video for positive discipline: https://www.youtube.com/watch?v=f-e4H2rsEww

Handout:
The five criteria for positive discipline are (Positive Discipline, 2008, https://www.youtube.com/watch?v=f-e4H2rsEww):

1. Being firm and kind with children
2. Do they feel a sense of belonging?
3. These tools work long-term
4. Teaching valuable life skills (communication, listening, self-regulation)
5. Developing sense of self-esteem, self-efficacy, ability to do things on their own

Can also explore this website: http://www.positivediscipline.com/what-is-positive-discipline.html

(Website contains a basic explanation of positive discipline, and the evidence behind it for those interested.)


Discussion points:

- What do you think about positive discipline?
- Are there elements of positive discipline in your parenting style?
- What do you like about it? What do you not like about it?

Activity 2 (View video, handout, and discuss “Flipping your lid” concept)

This activity can be printed out as a Handout for class:

View video here: https://www.youtube.com/watch?v=DD-lfP1FBFk for the hand model of the brain presented by Daniel Siegel, great simple explanation.

Daniel Siegel’s “Flipping Your Lid” diagram, found here (http://www.earnestjourney.com/2014/05/26/balancing-act/):
And also Parenting From Scratch (2012) provides this link
https://parentingfromscratch.wordpress.com/2012/09/11/flipping-our-lids-and-closing-them-again/, which could be used as a handout for class:

“Parenting Through Flipped Lids

So, what can parents do when emotions run strong? Dr. Jane Nelsen, author of Positive Discipline, offers a few tools that help during “flipped lid” moments:

Hugs. When your child flips her lid, a hug may be the last thing you want to offer. But it might just be the thing she needs most. The mirror neurons in her brain assess the emotional state of the people around her and influence her reactions. When her brain picks up on the loving composure in a hug, its chemistry begins to return to a calm state; her ‘flipped lid’ begins to close.

Positive Time Out. This is perfect for when either you or your child has a flipped lid.

Before reacting to your misbehaving child or your favorite collectible that mysteriously
broke, take a few minutes alone to calm down and restore your brain chemistry. The problem—the one that triggered your flipped lid—will still be there when you’re feeling better. Communication will go much more smoothly when you have access to your rational brain. With time and practice, you can also teach your child how to take a positive time-out for himself when he’s upset and needs to calm down.

Focus on Solutions. This is for when you’re about to flip your lid, or have just calmed down after one. Yes, there’s a huge mess on the floor. Yes, your two-year-old is bothering his older (and now very annoyed) sibling again. Yes, someone lost an important item again, or someone else is dawdling to get ready…again. But rather than get mad and yell (again), focus on practical solutions to these problems. Instead of thinking, ‘What can I do to you so that you’ll learn?’ think, ‘What can I do to help you succeed with this? What solutions can we come up with?’

Apologize. For those times when you do flip your lid, a sincere apology helps to emotionally reconnect you and your child. Tell your child, ‘I’m sorry I yelled. I’m sure that must have hurt your feelings. You were upset, and you needed to feel better, not worse. I’d love to hear your ideas on how to fix this.’

So, flipping your lid, while not ideal or sometimes even avoidable, does provide an opportunity to model and teach some valuable skills to our children: cooling off, self-control, problem solving, and, probably most importantly, emotional recovery and reconnection after a hurtful situation.”

Discussion points:

• The importance of reconnecting and repair after a hurtful event.
• What did you think about the handout’s emphasis on RE-focusing on solutions, shift in attitude?
• What did you think of the idea of giving both yourself and your child a positive time-out?
• We’ve been going over a lot of material that says that it’s important to address the emotional (limbic) before the rational part of the brain when there is an incident (e.g., tantrum, etc.), by giving hugs or saying kind words. What do you think about that? How difficult or easy is that for you to do? [We can practice that in class.]

**Activity 3:**

Now, let’s practice these skills with each other, focusing on problem areas if you like (for instance if you have trouble with yelling, practice the positive time-out, then focusing on solutions, or alternatively the apology part). Pair up and try out; please ask permission before trying any touch activities. Then discuss as a group what that was like.

**Closure:**

Depending on time left in the session, the facilitator could ask the group:

• How did that go for everyone?
• What was useful about the session? What did you find not as useful?
• What would you like to see more of?
• What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how
long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

*Next week’s topic is:* Practical activities; it might be best to provide a handout of possible activities for next week today, then ask parents which ones they would like to explore, so that you have time to prepare if there are materials involved in the activity. (You may also want to consider if parents want to bring their children for the next session to try these activities with their children.)

*Optional Activities:*

The following video explains the value of positive praise, but done in a way that is specific.

Praise:

[https://www.youtube.com/watch?v=Wqo4c-FlFGE](https://www.youtube.com/watch?v=Wqo4c-FlFGE)

Kidsinthehouse - Tips for praising children properly - Dana Etin

Activity: Try the praising. Pretend that your child has done something well (say like they did their homework or something more appropriate to your life), and now you want to praise them.

The following video explains logical consequences, and

Logical consequences:

[http://youtu.be/KukQfLvgCk8](http://youtu.be/KukQfLvgCk8)
(Send a message that every choice and action has a consequence. 2, you are responsible and you have a power to change it.

Pre-conditions: Assertively told them what to do, taught how to do it, given them choices to help be successful, celebrated and encouraged them a lot

You have a choice….You can take turns and cooperate until your friend has to leave, or you can continue…

Stop the video, and discuss:

- What is the difference between consequence and punishment? (reflection vs. guilty/bad)
- Do you currently practice this at home? Is it consistent? Would you like to practice?

Activity: Try practicing offering choices to your child with a partner.

Handouts:

http://www.caringforkids.cps.ca/handouts/tips_for_positive_discipline
http://www.caringforkids.cps.ca/handouts/guiding_with_positive_discipline

(This one also addresses the effects of developmental stage and temperament on discipline).

Another good one: http://afineparent.com/be-positive/positive-discipline.html

Alternate discussion/activities:
Really simple link on positive parenting (from http://www.childtrauma.com/publications/pos-par):

- Keep your promises
- Stop a problem quickly
- Enjoy your child

Understanding problematic behavior (it’s not personal), Bryan Post from Postinstitute (2009), https://www.youtube.com/watch?v=x5Xw75lv3t8.

3 principles:

“All behavior arises from a state of stress.”

“Negative behavior arises from an unconscious state (Scared children do scary things”).

“There is negative and positive repetitious conditioning.” (Behavior is a byproduct, for both parent and child; the only way to overcome is to do something different to re-condition)

There is also a great blog post that talks about Daniel Siegel’s ideas in a simple and concise way, highlighting how resilient children come from, and also models for parents what to do after they lose it (something that is also explored in the later session on Positive Discipline): http://www.thetwincoach.com/2011/06/compassionate-resilient-children-begin.html

Another great blog post that is a follow up to the first one noted above, which covers in detail the workshop the blog writer attended with Daniel Siegel and Tina Bryson (2011),

(The second post covers a little bit on left brain vs. right brain, connecting and redirecting, understanding why children misbehave, the idea of discipline as a teaching moment, downstairs vs. upstairs brain, how to help your child develop the upstairs brain, the downside of timeouts.)
Week 11: Specific Activities

Desired outcome: You will have greater knowledge of and be able to practice specific activities with your child that are healing of trauma.

Notes to facilitator: I decided that it would be best to provide a handout of possible activities first, then ask parents which ones they would like to explore today (it might be best to do this during the previous week, so that you can prepare materials if needed). I had some difficulty picking specific activities for this one, partly because there are activities already in the curriculum elsewhere that correspond to specific topics. For this session, I decided to pick activities that were specifically meant to build on either attachment or other brain re-orientation. Some of the activities seem so simple, or are simple variations of common children’s activities, so may not seem to interesting to some parents.

Before beginning, I think that it’s important to frame the activities in a way that explains briefly the why they are important, what function they serve. It would be easy for a parent to say, “Yeah, our kids already do all that stuff. That’s nothing new. Reading, nature walks, games, so what.” So, I think it’s really critical to explain why they are important, so that these activities don’t just get blown off or filed away as something that they already do.

I believe that it’s important to explain that the brain develops in a use-dependent way, and that it is critical to provide a stimulating learning experience for children to grow (Perry, 2006). It is through these activities that children develop skills (both social,
emotional, and cognitive) and learn how to treat others. For instance, reading and talking provides language skills; nature walks help with muscle coordination and smells; games help with cooperation and perhaps touch; cleaning house helps with cooperation, responsibility, and contributing to something greater than themselves. It may also be useful to read from the “Foundations” section of “Doodles, Dances, and Ditties” (Hiebert et al., 2013) of the appropriate section if those activities are chosen.

Day at a glance:

Activity 1: Explaining and discussing the why behind the activities from “Doodles, Dances, and Ditties” (Hiebert et al., 2013). (15 min).

Activity 2: To be determined by facilitator (15 min).

Activity 3: To be determined by facilitator (20 min).

Detailed activity plan:

Today, we are going to talk a little bit about why certain activities can be useful for helping re-orient the brain. We are then going to go over a list of possible activities, and you will be able to choose which ones to go over in more detail. We will then have a chance to get further in depth for a few specific activities, and to practice them.

[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust….”

Check-in about what parents may have tried last week regarding positive discipline. If nobody had tried anything, could ask about what they did try, and how that went.

Activity 1
Talking points:

- The brain develops in a use-dependent way, and that it is critical to provide a stimulating learning experience for children to grow (Perry, 2006).
- It is through these activities that children develop skills (both social, emotional, and cognitive) and learn how to treat others.
- For instance, reading and talking provides language skills; nature walks help with muscle coordination and smells; games help with cooperation and perhaps touch; cleaning house helps with cooperation, responsibility, and contributing to something greater than themselves.
- Some of these activities you already know how to do, but we’ll also give you some variations of common activities that can especially help with healing from the effects of trauma.
- Read together and out loud the “Foundation” subsections (i.e., Sensory integration, Self-regulation, Relational, Cognitive) found at the beginning of the various parts of the book “Doodles, Dances, and Ditties” about the activities that are chosen before doing them.

**Provide handout, possible list of activities below:**

**Possible activities:**

Attachment-based activities:

Theraplay (video example and also the written stuff from above somewhere):

Theraplay games (Theraplay example from a parent):

https://www.youtube.com/watch?v=QmQbtMQiMck

Link to Theraplay book (Munns, 2009), lots of activities as well as the theories behind Theraplay:

http://file.zums.ac.ir/ebook/268-

Applications%20of%20Family%20and%20Group%20Theraplay-

Evangeline%20Munns%20Nancy%20Atkinson-076570594X-Jason%20A.pdf

Link to Activities that are useful (See App. B for Theraplay list of activities above, and also Marchak interaction activities):
Sensory Integration (“Doodles, Dances, and Ditties”, Hiebert et al., 2013):
Creative activities such as “Found Object Art”, p. 24; “Edible play dough”, p. 25;
Making your own instruments (p. 26); It’s moving time now song (p. 28); Self-massage (p. 30); Finding your heart (p. 32); Rocking a stuffed animal to sleep (p. 34);
Jumping/bouncing (p. 36)

Emotional first aid and self-regulation activities:
Emotional first aid activities (e.g., the trauma story, coaching a child through their processing, Tracks 9 to 12 of Levine, 2004).
Self-regulation (“Doodles, Dances and Ditties”, Hiebert et al., 2013): Volcano breath (p. 44), Progressive muscle relaxation (p. 50), Energy meter (p. 51), Freeze dance (p. 53), Guided visualization (p. 57), Paper mosaic (p. 63), Rhythmic imitation (p. 64)
Zones of Regulation, which can be used to help children become more aware of their emotions and how to better manage them:
http://www.zonesofregulation.com/

Relational (“Doodles, Dances, and Ditties”, Hiebert et al., 2013):
Painting with water (p. 73), Pushing hands (p. 74), Mirroring (p. 77), Rock the monkey (p. 81), Gift-making (p. 81)
Cognitive ("Doodles, Dances, and Ditties", Hiebert et al., 2013):
Safety hand (p. 89), Haiku (p. 90), Rhythmic story (p. 92), Inside/Outside box (p. 93), Desert Island (p. 95)

Social skills activities:

Closure:
Depending on time left in the session, the facilitator could ask the group:

- How did that go for everyone?
- What was useful about the session? What did you find not as useful?
- What would you like to see more of?
- What is one thing that you learned from the session, and one thing that you plan to try over the next week?

(Another option could be to focus on the last question in particular. That might be plenty for a larger group.)

Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

Next week’s topic is: Closure/Final session.
Optional Activities:

The ebooks, note how you have to register (for free) to get one, but that they can be obtained from: http://peaceinyourhome.com/turn-misbehavior-into-cooperation-parenting-ebook-by-kathryn-kvols/

[Child Trauma Academy (2014), https://childtrauma.org/wp-content/uploads/2014/07/Study_Guide_The_Boy_Who_Was_Raised_as_a_Dog.pdf, Chapter 4: 1. “When two patterns of neural activity occur simultaneously with sufficient repetitions, an association is made between the two patterns.” (p.85) How can this oft-repeated principle of Dr. Perry’s be taken advantage of by the classroom teacher and school staff? (think pleasure, human interaction, and learning in concert)]

- Repetitive patterning, physical exercises with rhythm (see http://www.youtube.com/watch?v=ZVRO7PdYRnM)

Also, this is a great summary of some of the main points of Siegel & Bryson’s (2011) “The Whole-Brain Child”, http://www.thetwincoach.com/2011/10/brain-science-that-will-blow-your-mind.html

It contains a good explanation of the first 4 strategies, namely:

1. Connect and Redirect: Surfing Emotional Waves
2. Name It to Tame It: Telling Stories to Calm Big Emotions
3. Engage, Don't Enrage: Appealing to the Upstairs Brain
4. Use It or Lose It: Exercising the Upstairs Brain"
**Week 12: Final Session**

*Desired outcome:* You will have an opportunity to discuss what you will do outside of this class to continue your own education, and also to find and provide each other with support if desired. You will also have an opportunity to re-

*Notes to facilitator:* I left this session particularly open-ended, because I think it will really be important to allow the group to dictate where they are going, and what they learned from the sessions. For this curriculum to be truly empowering, there has to be a way to encourage parents to continue with their growth in educating themselves and also in taking a greater role in building their own support networks, such as the Parent Café. I do provide links to Parent Café, in case that is a direction that parents want to go. You can also remind them that the protective factors session was based strongly in materials from the Parent Café.

*Day at a glance:*

Activity 1: Discussion about what was learned and what people are grateful for (25 min)

Activity 2: Discussion about future plans (25 min)

*Detailed activity plan:*

Today, we are going to talk a bit about what you’ve learned over the past several weeks, and also what your plans are for providing each other support and continuing your efforts to learn and grow in the future when it comes to helping children heal from the effects of trauma.
[Before check-in]: Read brief summary of what the group agreed upon in Session 1. For example, “These are the rules we established to provide an atmosphere of safety and trust…."

Check-in about any thoughts about the activities last week, and if parents had a chance to try these at home. If not, that’s ok. Which ones did you like in particular?

Activity 1 (Discussion about what was learned)
Discussion points:
• What did you learn from this class? Did you feel that it was helpful? What did you like? What would you have liked different?
• ID what you learned about your child or yourself during the sessions, and what you would like to work on going forward.
• What are you grateful for when it comes to your family and your child? What are your strengths as a family?

Activity 2 (Discussion about next steps)
Discussion points:
• What are your hopes for the future?
• What are the next steps for you?
• Who are your supports?
• How are you going to make this happen? Break into smaller groups if necessary and work together to talk about a specific plan.)
• Discuss Parent Café and the possibility of parents providing each other with additional support, see http://www.bstrongfamilies.net/

Closure:
Thank you all for helping us to better understand your needs, and for helping also teach us about what is important to you. We hope that we can continue to provide you with whatever help you need before you leave here, so that you can have a healthier and happier family that is sustainable in the long run.
Before we close for today, we want to invite people to take what they would like from today’s group and to leave anything here that they do not want to take outside of the room with them. We will have a brief moment of silence (facilitator’s discretion for how long; could be 1 to 3 minutes signified by a bell or singing bowl, for example) before breaking.

*Optional Activities:*

The facilitator could provide a handout with many useful links for parents, including those that were explored throughout the curriculum. This list might include informative websites, useful videos, practical tips, research articles, link to “Living the Protective Factors” (Wolf, 2012), “101 Social skills” (Shapiro, 2014), and Turning Misbehavior into Cooperation” (Kvols, 2008) ebook link.