Art Therapy Group for Child Survivors of Abusive Homes: The Therapist’s Guide

A graduate project submitted in partial fulfillment of the requirements

For the degree of Master of Science in Counseling,

Marriage and Family Therapy

By

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Dedication

Dedicated to my loving parents, who fostered an environment of unconditional love and support and who have inspired me to achieve my childhood dream of becoming a marriage and family therapist.
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Abstract

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By:

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Master of Science in Counseling, Marriage and Family Therapy

The purpose of this project is to provide clinicians with a guide for implementing group therapy treatment, for children and families who have experienced physical and emotional abuse in the home. This project will provide clinicians with relevant research regarding the prevalence of child physical and emotional abuse, the effects of trauma, and methods for treating this population. This project details a structured session-by-session format, to aid clinicians in facilitating this type of group. While this project provides clinicians with suggestions and guidelines, the project also allows room for clinicians to be creative, tweaking the session materials as clinicians see fit. The goal of this project is to be a clinical tool for clinicians to add to their clinical skillset.
Chapter 1

Introduction

Statement of Need

The purpose of this project is to create a guide for clinicians to facilitate group therapy for children who have experienced physical and emotional abuse. In the United States, according to Childhelp (2015), more than 3 million child abuse reports are made, annually, affecting more than 6 million children. This averages out to 1 report of child abuse every 10 seconds (2015). With the knowledge of prevalence of childhood physical abuse, comes the knowledge of the effects physical abuse has on children. According to Finzi, Har-Even, Ram and Weizman (2003), physically abused children are at a higher risk for developing behavioral, emotional, intellectual, and social disorders. Additionally, Finzi-Dottan and Harel (2014) assert that individuals who experience physical abuse, as children are at higher risk for becoming abusive parents themselves.

The proposed group will help children, who have experienced abuse, to process and cope with their trauma. This project is necessary because it will provide clinicians with a different framework for treating children who are victims of abuse. As marriage and family therapists, providing families with resources, psychoeducation, and coping mechanisms for dealing with child abuse is an invaluable tool. This group is necessary to help children process and cope with the trauma of being abused, in hopes of decreasing the possibilities of other challenges arising, and in an effort to break the intergenerational cycle of abuse. The group will address the parents’ needs, focusing on processing, psychoeducation, and coping mechanisms.
This project uses the popular Evidenced-Based-Practice (EBP), Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), while leaving room for clinicians to be creative, utilizing different art therapy interventions. TF-CBT has been proven effective in treating trauma in youth from ages 3-18 (Solano, 2006). TF-CBT is a highly structured practice, which provides clinicians with a how-to guide for implementing adequate treatment. With statistics proving the high prevalence of child abuse, clinicians need more tools to help provide support for clients and families who have experienced child abuse. The goal of this group is to meet this need, providing clinicians with a user-friendly guide to facilitate a therapy group, founded upon the TF-CBT model.

**Purpose & Significance**

The purpose of this project is to provide children who have experienced abuse with a safe environment for processing and coping. The purpose of this project is also to provide clinicians with a how-to guide, to implement TF-CBT in a group setting, using art therapy interventions. Hopefully, this project will contribute to the field by assisting other therapists in helping to treat children who have been victims of abuse.

The group setting is a suitable fit for children, since researchers such as Jacobs, Mason, Harvill and Schimmel (2012) have proven this type of therapeutic setting to be effective. Children, who are often self-conscious and shy, may find the group setting valuable, as they are awarded with the opportunity to hear similar thoughts and feelings from their peers. This can be an invaluable tool, as many children feel as though they are alone in the feelings and thoughts that they hold (2012). Yalom and Leszcz (2005) postulate that the group setting can foster social learning, social support, and can be especially effective when the group members experience
stigma associated with the presenting concern. Finzi-Dottan and Harel (2014) point out that considering there is much stigma and shame associated with being physically abused, the group setting is an effective choice for counseling this population. Furthermore, since children process events differently, it is recommended that art and play therapy interventions be introduced in the group setting (Jacobs et al., 2012). For the sake of this group, art therapy interventions will be incorporated, as art therapy interventions have been found especially useful when working with children. According to Rubin (2005), in the group setting, children may feel a sense of a safety and support from other group members, thus, making it easier to share art, which could otherwise be difficult for some children.

**Terminology**

In order to better understand the argument put forth in this master’s project, it is important to understand the meanings of the following terms, which will be used throughout the paper:

EBP: evidenced-based practice, with empirical evidence supporting its effectiveness.

Abuse: for the purpose of this paper, the writer will refer to two types of abuse-physical and emotional. Physical abuse includes any physical harm that leaves a mark or lasting pain. Emotional abuse is the witnessing of domestic violence, or other acts of parent-child abuse (i.e. witnessing a sibling being abused).

Trauma narrative: according to Solano (2006), the child’s story of traumatic events (created with help of therapist), to help the child cope with the trauma.

Conjoint child-parent sessions: where child’s parent/s are invited into the therapy session to listen to the trauma narrative (Solano, 2006).
Psychoeducation: teaching the child and parent about prevalence of trauma, types of trauma, and effects of trauma (Solano, 2006).

Parenting Skills: according to Solano (2006), these are the techniques taught to parents by the therapist for managing maladaptive behaviors associated with trauma.

Affective expression and modulation: are used to help children to identify and appropriately express a range of emotions, as trauma can lead children to express emotions in a negative manner (Solano, 2006).

DCFS: Department of Children and Family Services

The terms parents/caregivers will be used interchangeably. In addition, intergenerational patterns will be used to refer to the common patterns present in a family, amongst different generations (i.e. patterns of abuse).

In order to better understand the effects of trauma on children, it is crucial to: review and explore the literature detailing child abuse; the effects of trauma on the developing brain, behaviors, and cognitions in children; to explore the effects of abuse on parent-child relationships; and to discuss therapies in helping children overcome these issues.
Chapter 2

Literature Review

This chapter will begin by defining the system of child abuse, covering different areas such as symptoms and areas of impact, the parent-child relationship, parents as perpetrators, and risk factors. After the system of child abuse is defined, this chapter will begin discussing appropriate interventions and treatment modalities to help treat clients who have experienced child abuse, based upon the TF-CBT model. A detailed explanation of what TF-CBT is, research supporting TF-CBT, and the breakdown of how to implement TF-CBT, will all be described in this chapter.

Symptoms of Abuse and Areas of Impact

Finzi et al. (2003) assert that there are considerable differences between children who have been abused, and children who have not. Children, who are at a continuous stage of rapid development, develop differently when a trauma or multiple traumas have occurred. Parental maltreatment can hinder a child’s everyday functioning, as well as the complete life development of the child. Children who experience abuse are at a higher risk for different emotional, behavioral, social, and intellectual disorders. These challenges not only impact a person during childhood, but can also follow the child into adolescence and adulthood (Finzi et al., 2003). Ward and Haskett (2008) contend that children who have been abused are more likely to withdraw, have more trouble making friends, and are more likely to demonstrate aggression.

While there are many different types of abuse a child can endure, each type of abuse can impact a child differently. Typically, Finzi et al. (2013) posit that physically abused children exhibit more aggressive, impulsive, and non-compliant behaviors than children who have
experienced other forms of abuse. Physically abused children also experience more cases of depression, anxiety, suicidal behavior, substance abuse, delinquency, and self-harm (Finzi-Dottan & Harel, 2014). According to Finzi et al. (2003), these types of behaviors lead to difficulty forming close, healthy interpersonal relationships with others. In addition, problems related to socioemotional adjustment of physically abused children tend to worsen with age, whereas these problems tend to decrease over time in children who have experienced other forms of abuse.

Finzi-Dottan and Harel (2014) note that according to cognitive behavioral approaches, children who experience abuse tend to develop maladaptive beliefs about the self. These beliefs include feelings of helplessness, incompetence, unworthiness, and the belief that one is unlovable (2014). Additionally, children who withstand stressful life events such as physical abuse may exhibit deficits in attention and memory (Bridgman, 2013).

In addition to emotional, behavioral, social, intellectual, academic, and psychological adversities, in severe cases, childhood physical abuse can result in death. According to the U.S. Department of Health and Human Services (DHHS, 2013), it was reported in 2012 that an estimated 1,640 child fatalities resulted due to child maltreatment. The younger a child is, the higher the risk for fatality resulting from child maltreatment. Of the 1,640 childhood fatalities, about 44% resulted from physical abuse (2013).

The Parent-Child Relationship

The parent-child relationship is essential, as its impact on functioning helps to mold the child, developmentally. Ward and Haskett (2008) suggest that children who experience warm, engaging relationships with caregivers tend to exhibit more socially acceptable behaviors than
children who experience maltreatment. Finzi et al. (2003) postulate that according to the Attachment Theory, the initial relationship between child and primary caregiver/s serves as the foundation for all future relationships in a child’s life. Attachment relationships are crucial, as they impact different levels of functioning including affect regulation, social skills, interpersonal relationships, and coping mechanisms. Attachment Theory divides attachment into three different styles; secure, anxious/ambivalent, and avoidant. The more secure the attachment, the healthier the relationship between parent and child. The attachment style between parent and child encourages the child’s survival instincts (Finzi et al., 2003). Finzi-Dottan and Harel (2014) believe that when a child has a secure attachment, a child is able to cope with stress and regulate affect. However, when a child experiences abuse, these survival instincts are threatened. When relating Attachment Theory to abused children, Finzi et al. (2003) indicate that physically abused children have insecure attachments to their primary caregivers. The parent-child relationship is of concern when it comes to physically abused children, as this relationship is the pre-cursor for all future relationships. Children who are physically abused may look for similar styles of relationships, as they mature, which could lead to future unhealthy relationships patterns (2003).

**Parents as Perpetrators**

Most child physical abuse occurs at the hands of a caregiver, while other instances of child physical abuse may occur at the hands of someone close to the family. According to the most recent publication of the DHHS (2013) 81.5% of children who experienced abuse were maltreated by one or both parents. 36.6% were abused solely by their mothers, 18.7% were abused solely by their fathers, and 12% of children were abused by a party who was not a caregiver. 19.4% of children who were abused, were abused by both parents (2013).
Risk Factors

While child abuse can impact families across different socioeconomic statuses, religions, races, and ethnicities, there are certain risk factors associated with the likelihood of childhood physical abuse occurring. According to the DHHS (2013), caregivers who experience domestic violence, including both the perpetrator and non-perpetrator, are at a higher risk for physically abusing their children. Additionally, caregivers who have substance abuse problems with alcohol and/or drugs are also at a higher risk for physically abusing children. While substance abuse problems with both alcohol and drugs put children at increased risk for physical abuse, caregivers who abuse drugs are at a higher risk than caregivers who abuse alcohol (2013).

According to Finzi-Dottan and Harel (2014), other risk factors associated with predicting the possibility of parents physically abusing their children include intergenerational patterns. Although not all children who have experienced physical abuse grow up to be perpetrators, there is an abundance of research detailing a strong correlation between parents’ experiences of childhood physical abuse, and physically abusing children. Parents, who have experienced physical abuse in their own childhood, are 6 times more likely to physically abuse their own children. Additionally, mothers who do not have secure relationships with their caregivers are about 12 times more likely to physically abuse their children, than mothers who have emotionally secure relationships with their parents. These findings are believed to be a result of negative developmental effects that physical abuse can have on a child, which translates into adulthood. The ability of an abused child to parent may be negatively impacted due to the abuse that individual experienced as a child (Finzi-Dottan & Harel, 2014).
An abusive parenting style can also be predicted by the amounts of stress that caregivers experience. Caregivers who are under more stress are more likely to exhibit abusive parenting styles. The ability for a parent to cope with stress relates to the parent’s attachment. Parents who are securely attached are less likely to exhibit abusive parenting styles while under stress, than parents who are insecurely attached (Finzi-Dottan & Harel, 2014).

While physically abusive caregivers range from different ethnic, racial, and cultural backgrounds, Elliot and Urquiza (2006) indicate different rates of abuse within different backgrounds. According to data provided by these researchers, African American and Asian American parents are more likely to physically abuse their children. The ranking continues from a higher prevalence of childhood physical abuse, to a lower level with Latinos, Whites, and mixed-race children. Children of American Indian and Pacific Islander decent display the lowest prevalence of childhood physical abuse. Elliot and Urquiza also suggest that the prevalence of childhood physical abuse is also in part due to other factors aside from parents’ ethnic, racial, or cultural backgrounds. Other factors impacting prevalence are socioeconomic status, acculturation, and neighborhoods where families live (2006).

**Art Therapy & Trauma**

According to Eaton, Doherty, and Widrick (2007), art therapy offers clients an outlet for expression in a safe environment. Art therapy has been used to successfully help clients heal from different psychological stresses. Different forms of creative arts therapy are becoming increasingly favorable methods of therapeutic treatment. Art therapy, music therapy, dance therapy, poetry therapy, and psychodrama are all different versions of creative arts therapy (2007). Van Westrhenen and Fritz (2014) contend that there is expanding evidence based upon
the effectiveness of creative arts therapy and trauma, especially childhood trauma. This has to do with the memories of trauma, which can be visual and sensational, much like these different forms of art (2014). According to Eaton et al. (2007), therapists utilize art therapy interventions that meet the needs of the specific population being treated. Since the therapeutic relationship is one of the most valuable factors in therapeutic outcomes, therapists working with traumatized youth who are using art therapy utilize art interventions to help build rapport with their clients. When treating and working with children, popular modalities of art therapy are painting, drawing, sculpting, and coloring. As sessions progress, the child may be asked to use art as a form of storytelling, while the therapist helps to facilitate meaning and interpretation of the child’s artwork (2007).

Finzi et al. (2003) assert that information regarding symptoms and areas of impact, child development, the parent-child relationship, parents as perpetrators, risk factors, and art therapy and trauma, help to dissect the contributing factors of working with this population. When working with this population in a group setting, it is crucial to understand the symptoms they live with and the threat these symptoms cause to everyday functioning, which can stem from the exposure to trauma. It is essential to understand these unique symptoms, so that the facilitator can target these symptoms and areas of impact in the group setting. This is especially important when working with a young group, as children who have experienced trauma are at higher risk of developing other behavioral, social, and psychological issues later in life (Finzi, 2003).

The importance of understanding child development and the stage of development that group members are in is necessary, as it will help the group facilitator in creating an appropriate group curriculum. This includes the types of interventions, which will be implemented, based upon the age group and developmental stage of the participants. Understanding the parent-child
relationship will help the facilitator to establish levels of attachment and development for each individual group member. This will also be important when implementing the TF-CBT model, as parent involvement is key (Solano, 2006). Parents as perpetrators and risk factors associated with offenders will help the facilitator to educate the parents and children in the group, in hopes of breaking the intergenerational cycle of abuse. Lastly, art therapy and trauma relays the effectiveness of using art therapy interventions in the treatment of children who have experienced trauma (2006).

**Intervention Models**

**TF-CBT.** The structure of this group will be based upon the TF-CBT model. According to Solano (2006), this is an evidenced-based practice typically used for treating trauma in youth who range from 3-18 years of age. Cohen, Mannarino, Kliethermes, and Murray (2012) state that complex trauma impacts a person on many different levels and domains including behavior, affect, self-image, cognitions, and academic functioning, as well as other PTSD symptoms. Solano (2006) points out that TF-CBT is divided into 9 categories, creating the acronym “PRACTICE”. Each letter in the word represents a different area to be covered in treatment.

**Psychoeducation & parenting.** According to Solano (2006), one of the overarching themes of TF-CBT is to establish a therapeutic relationship between therapist and client, in order to provide the client with a healthy model for a relationship. Later on, the focus is shifted towards the client forming healthy, safe relationships with others, including the client’s caregiver. Establishing a strong therapeutic relationship is attempted during the first stages of treatment and is continually worked on throughout therapy. At the start of treatment, psychoeducation is introduced as a means of educating clients and caregivers. Psychoeducation
informs youth and parents about trauma, the effects of trauma, and treatment options. The material presented to clients and caregivers is altered based upon the specific trauma experienced and the developmental level of the child. It is during this section that youth identify trauma themes, which help them to paint a picture of their complete trauma experience (2006). Cohen et al. (2012) posit that the importance of incorporating parents in the TF-CBT is to either strengthen or rebuild the relationship between parent and child. This will be especially valuable for children participating in this group, as relationships between parents and children may be strained due to the abuse. Even if the parent participating is not the perpetrator, there may still be a strain on the relationship, due to the child having feelings regarding the non-offending parent’s inability to protect the child from harm. Parents participate in session in hopes of educating themselves so that they are better equipped to cope with their child’s trauma (2012).

According to Solano (2006), the TF-CBT treatment modality focuses on helping both the child who has experienced the trauma, as well as the parent/s of the child. Therapists meet with parents to help them gain a better understanding of their child’s trauma, as well as feelings, thoughts, and behaviors related to the trauma. Therapists teach parents effective strategies for managing and coping with their child’s fears, unwanted behaviors, sleep problems, and non-compliant behaviors. This aspect of treatment aims to decrease inadequate parenting techniques, which can contribute to the child’s non-compliance and other unwanted behaviors. The goal is to help parents adapt an effective style of parenting, to help strengthen the parent-child relationship (Solano, 2006).

**Relaxation.** Children who endure trauma may also experience fears and anxiety as a result. According to Solano (2006), relaxation skills are taught to both children and caregivers to help alleviate the physiological symptoms of fear and anxiety. Relaxation skills help the child
who is experiencing physiological symptoms of fear and anxiety because when the body is calm, the perceptions associated with fear and anxiety decrease. This is an important skill, as it empowers children to become more in control of their fears, anxieties, and associated symptoms (2006). Cohen et al. (2006) point out that youth who have experienced trauma, also experience difficulties with self-regulation. As a result, these youth adopt maladaptive coping mechanisms such as acting out in school, drugs, alcohol, and so on. Physical based relaxation techniques are utilized to help youth find more healthy coping mechanisms. Physical-based relaxation techniques can include yoga, mediation, dance, progressive muscle relaxation, focused breathing, pleasant imagery, and meditation, amongst other methods. Children and caregivers are encouraged to practice these learned relaxation skills outside of therapy (Solano, 2006).

**Affect expression and modulation.** According to Solano (2006), a wide range of negative emotions including shame, guilt, anger, sadness, fear, and disgust, can plague youth who have experienced trauma. These emotions can be challenging for youth to identify, understand, regulate, and express. Thus, youth may express these emotions in an unhealthy way (2006). Cohen et al. (2012) articulate that learning to identify and express emotions can be a stressful experience for traumatized youth, as they may have learned to internalize their feelings as a safety mechanism. Similarly, Solano (2006) points out that parents may also hold a range of negative emotions about their child’s trauma. The therapist helps children and parents to acquire the necessary skills to appropriately identify, understand, process, and express emotion in a healthy manner (2006).

**Cognitive coping and processing.** Solano (2006) asserts that this aspect of treatment aims to acknowledge the relationship between thoughts, feelings, and behaviors. Thoughts and feelings about the experienced trauma are examined in order to help clients gain a better
understanding of behaviors, which are related to the traumatic events experienced. This is the point in treatment where cognitive distortions, or negative, unhelpful, and inaccurate thoughts regarding the trauma, are challenged and replaced with more positive thoughts. This helps clients to become more aware of the different effects maladaptive and positive thoughts can have on behavior (2006).

**Trauma narrative.** According to Cohen et al. (2012), the Trauma Narrative is a processing phase where the youth creates a narrative, consisting of his or her thoughts, feelings, and behaviors, specifically related to the youth’s trauma experience. Solano (2006) explains that the process of creating a trauma narrative serves as gradual exposure, where the child is able to experience the negative feelings associated with the trauma in the safe environment of therapy. The narrative can either start at the onset of trauma or at the beginning of the youth’s life. Writing a narration, music, poems, drawing or other forms of art may be used as a part of the narrative making process (Cohen et al., 2012). According to Solano (2006), the method of creation for the trauma narrative depends on the age, interests, and developmental abilities of the client. The overarching goal of the trauma narrative is to help the client cope with the negative feelings and thoughts resulting from the trauma instead of avoiding them. This exposure helps to decrease the severity of symptoms and range of negative emotions. Since traumatic experiences can be difficult for children to talk about, the narrative serves as a familiar template for disclosing traumatic events (2006). Cohen et al. (2012) posit that through the process of creating the trauma narrative, the client discloses in detail about past trauma experiences, as new understandings and meanings arise. Examining core beliefs relating to the youth’s trauma themes help the client to process the trauma, which has occurred. This is where the therapist challenges any cognitive distortions, which may have formed as a survival mechanism for the client. The
therapist helps the client to process what has happened, and helps the client to discover alternative meanings and possibilities (2012).

In-vivo exposure. As a result of the experienced trauma, youth may experience certain trauma triggers. This may lead to avoidance of certain behaviors or activities, due to fear. Cohen et al. (2012) note that these triggers may be directly related to the trauma, or indirectly related. With the therapist carefully exposing the client to these triggers, the client is able to face their fears in a safe and productive environment. The goal of in-vivo exposure is to help the child reduce feelings of fear and anxiety, so that the child can have a higher level of functioning. According to TF-CBT research, gradual exposure has helped youth overcome these triggers and fears (2012).

Conjoint child-parent sessions. Since TF-CBT is a treatment modality primarily used for children, Solano (2006) contends that it is important to include caregivers in the phases and progress of treatment. The therapist meets with caregivers alone, to explain the process of the trauma narrative, and to prepare caregivers for upcoming conjoint sessions. The process of sharing the trauma narrative via conjoint parent-child sessions can be a stressful situation for many youth. The therapist should work with the youth, honoring the youth’s comfort with sharing the trauma narrative (2006). Ultimately the decision of when to share, and whether or not to share at all, should be up to the client (Cohen et al., 2012).

Enhancing future safety and development. In the closing phase of treatment, the therapist assesses the child’s sense of safety, addressing any concerns the child may hold. Solano (2006) states that one of the main goals is to help the child in developing skills that will ensure the child’s safety in the future. Another goal of this closing phase is to transfer the trusting relationship and secure attachment between therapist and client, to client and caregiver. This
involves the client inviting their parent/s into session, to share their traumatic experiences via the composed trauma narrative. In the conjoint sessions, the client shares the trauma narrative with the caregiver, detailing the specifics of the experienced complex trauma. The caregiver then has a chance to respond to the youth, in a caring and supportive fashion. This aids the caregiver and client in establishing a trusting relationship. Enhancing safety and trust is covered again during this closing phase of treatment as many youth may have need for more time to adjust to all of the changes and new skills acquired during therapy (2006). The therapist and client plan for the future by discussing possible or anticipated setbacks, and healthy ways of coping with anticipated setbacks (Cohen et al., 2012).

Evidence Regarding the Effectiveness of TF-CBT for Youth With Complex Trauma

According to Cohen et al. (2012), studies comparing TF-CBT and other treatment modalities widely used for youth who have experienced complex trauma, indicate that TF-CBT is effective in treating youth who experience emotional and behavioral problems, as well as other PTSD symptoms. Compared to SOC, Symptoms of Care model, TF-CBT was found to be more effective in improving these symptoms (2012).

TF-CBT & Target Population

TF-CBT is a suitable fit for the group that will be created in this project, as it has been proven effective for many different traumas including physical abuse, sexual abuse, domestic violence, natural disasters, unexpected death, and others. TF-CBT is specifically designed to work with children and caregivers, in an attempt to repair relationships, and help both children and caregivers to process the experienced trauma (Solano, 2006). This orientation is especially significant for this population, as many of the group participants experience strained relationships with their caregivers, as a result of the physical abuse endured. TF-CBT will
address the trauma the participants have experienced, as well as the attachment issues associated with this particular type of trauma.
Chapter 3
Project Audience and Implementation Factors

Recruiting and Screening Process

Yalom and Leszcz (2005) articulate that recruiting participants for a group is an important process, which contributes to the overall success of the group. Clients should also be involved in the selection process to make sure the group setting is an appropriate fit. Committing to a therapeutic group includes an investment of money, time, and the experience of multiple emotions, many of which can be unpleasant for clients. Thus, clients must be fully aware of the advantages and disadvantages associated with the group setting, to avoid premature termination, mid-treatment (2005). According to Yalom and Leszcz (2005) group participants are likely to continue with group therapy if the group’s goals are in line with the client’s personal needs, if satisfactory group relationships are formed, and if clients are satisfied with their participation in the group (2005).

In deciding whether or not participants will be a good fit for the group, it is important to look at if clients are experiencing problems in the interpersonal domain, according to Yalom and Leszcz (2005). This includes loneliness, problems with intimacy, social withdrawal, aggression, problems with authority, and feelings of unlovability. It is also important to look at the client’s desire and motivation for change, for if the client lacks motivation, he or she may not be a good fit for the group (2005). This information can be obtained via phone interview or personal interview. Jacobs, Mason, Harvill, and Schimmel (2012) posit that the personal interview method is one of the most efficient ways to screen for a group, as it provides both the facilitator and participants an opportunity to exchange valuable information.
Group Size & Characteristics

The minimum number of group participants is 4, while the maximum number is 6. This number refers to clients, not caregivers. This group will need to be smaller than most groups, due to the level of involvement needed by the group leader, based upon the TF-CBT model, as well as the conjoint parent-child sessions. Having too many group participants will make the conjoint sessions challenging, when multiple parents are invited to join. All participants in this group must have experienced both physical and emotional abuse in the home. This group will focus solely on the physical abuse and emotional abuse associated with witnessing either domestic violence or child abuse of a sibling. It is crucial that all group members have experienced both physical abuse as well as emotional abuse, to ensure that group members have similar, relatable experiences. The specifics of the experiences of physical and emotional abuse do not have to be the same for each participant, as long as each participant has experienced both. Furthermore, it is essential that each group member is in a similar stage of treatment, to ensure group cohesiveness. It is a requirement of this group that the participants have completed or are concurrently receiving family and/or individual therapy. It is also a requirement that the parent/caregiver who perpetrated the abuse, is either receiving services, has received services, or is out of the home, in an effort to ensure that the child is no longer being abused. The assessment for stage of treatment of participants will help the facilitator to screen out participants who are not ready to participate in this group. These requirements will also help to confirm the safety of each participant.

Some special considerations to evaluate when working with this population are the facts that the participants are minors, and have experienced trauma. Due to the fact that all of participants are minors, it will be necessary for the facilitator to explain the limits of confidentiality to both parents/caregivers and participants. Both parents/caregivers and
participants involved need to understand that while the group will be a safe place to process and disclose, the facilitator is still a mandated reported. Since this population has already experienced child abuse, it is not uncommon for additional abuse reports to surface. Additionally, parents/caregivers need to understand that while they will be informed of their child’s progress, each child’s confidentiality will be honored. Parents/caregivers will also be expected to participate in the group with their children, as part of the TF-CBT model (Cohen, Mannarino, Kliethermes, & Murray, 2012). Since this group is trauma focused, and each person processes and copes with trauma differently, the facilitator will be especially aware of each child’s progress and capacity to benefit from the group. If a child does not appear to be benefiting from the group, the facilitator will need to reevaluate the child’s position in the group.

Group Logistics

The group should take place in a private room at an agency or private practice setting, to adhere to confidentiality standards (Yalom & Leszcz, 2005). The room should be large enough to situate participants in a circle, to help encourage group discussion. The room should also have a table to provide working space for art interventions. This group is a closed group, with a predetermined time of 1.5 hours. As a closed group, in accordance with Yalom and Leszcz (2005), new group members will not be permitted to join mid-group as the group will be highly structured, following the TF-CBT model. The group will meet every week, for a total of 12 weeks. Attendance is necessary for all participants, as it is important that each participant complete each stage of the TF-CBT model. It will be challenging to make up material covered in these group meetings. Group participants will be allowed to miss no more than 2 sessions, or they will be dropped from the group. Additionally, there should be a 15-minute late policy for
each group meeting. Participants who arrive after the 15-minutes will not be permitted into the group for that session. All materials should be prepared and presented to participants, by the group facilitator.

**Facilitator Qualifications**

The group should have 1-2 facilitators, who will guide the clients through the weekly sessions. These individuals should be MFT trainees, MFT interns, Licensed MFTs, or licensed psychologists, who have experience providing individual, family, and group therapy. Jacobs, Masson, Harvill, and Schimmel (2012) express the importance of facilitators having ample therapy experience, working with many different types of individuals. They (2012) also emphasize the importance of having a lot of individual counseling experience, as it is hard to predict what situations can arise in the group setting. According to Jacobs et al. (2012), without prior individual counseling experience, leading a group can be a much more difficult task to accomplish. The facilitators should have knowledge of family systems, as this group will involve conjoint parent-child sessions. Since this group has a very detailed and structured format, the facilitators should hold prior group therapy experience. In addition to the qualifications and experience, attributes including patience, honesty, strength, sensitivity, warmth, objectivity, and transparency, have all been identified as common factors of effective group leaders. Facilitators should have experience monitoring group members’ feelings and reactions, in the group setting, as well as having comfort in a leader role. Like most therapy, facilitating a group can bring up personal issues for facilitators. Facilitators should be involved in their own self-care and therapy process, as necessary (Jacobs et al., 2012).
In addition to counseling experience, facilitators should be knowledgeable on the group’s topic of child physical and emotional abuse. Facilitators should have experience working with this specific population, as well as knowledge of the effects of physical and emotional abuse, symptoms, and common coping mechanisms. Facilitators should also be familiar with the TF-CBT model, as the group structure is based upon it. Being knowledgeable on this topic will allow for a more prepared group leader (Jacobs et al., 2012). Therapists have an ethical obligation to educate themselves on the group’s topic, before assuming a leadership role (Jacobs et al., 2012).

**Intended Audience**

This group is for children between the ages of 9 and 11. Both females and males may be present in the group, simultaneously. The interventions are specifically designed for the developmental level of this age group. However, interventions may be adapted as needed, to fit the developmental needs of the group, as TF-CBT can be used for children between the ages of 3-18, to treat trauma (Solano, 2006). Since this group is aiming to treat trauma, which can be a difficult aspect of treatment, it is important that the group members have similar experiences. For the purpose of this group, individuals must have experienced physical and emotional abuse by a caregiver. It is important that individuals have experienced the same types of abuse, so that they are able to relate to other group members. Furthermore, if there are individuals who have experienced different types of trauma, hearing about these different types of trauma can be traumatic for other group members.
Project Outline

General Group Overview

• The focus of this group will be to help the participants learn effective and positive coping strategies for dealing with stress related to traumatic experiences of physical and emotional abuse (Solano, 2006).

• The goal is to help the participants reduce negative symptoms resulting from their traumatic experiences (Solano, 2006).

• The overall hope for the participants of this group, is that they gain a better understanding of traumatic experiences, are able to process traumatic events, feel supported by peers, and are able to cope with trauma-related stress.

Session 1

• Goal/Focus
  o The Group: explain what the group is about, expectations/requirements of group, session breakdown, and goal of group
  o Consent: initiate informed consent with parents and participants, explain limits of confidentiality and agency policies
  o Rapport Building: to begin building rapport with participants by initiating icebreakers

Session 2

• Goal/Focus
  o Psychoeducation & Parenting
    ▪ Psychoeducation for parents and children regarding trauma, effects of trauma, symptoms of trauma, coping mechanisms, and effective treatment
• Psychoeducation regarding development of children and appropriate responses for age/development
  ○ Identification of clients’ trauma themes

Session 3
• Goal/Focus
  ○ Relaxation Techniques: skills are taught to clients, to help alleviate symptoms of anxiety, fears, and depression, stemming from trauma
  ○ Psychoeducation of positive effects of relaxation techniques, and how to implement techniques outside of therapy

Session 4
• Goal/Focus
  ○ Affect expression and modulation to address negative feelings associated with trauma, such as guilt, shame, sadness, fear, and anger
  ○ Help clients acquire necessary skills to identify, process, and express emotions related to trauma

Session 5
• Goal/Focus
  ○ Cognitive coping and processing
  ○ To connect relationship between clients’ thoughts, feelings, and behaviors
  ○ Therapists help clients to process thoughts and feelings about the experienced trauma, so clients can gain an understanding of why they exhibit certain behaviors

Sessions 6 & 7
• Goal/Focus
o Constructing the trauma narrative, where clients include thoughts, feelings, behaviors, and experiences associated with the trauma

o Clients will use drawing, painting, writing, and other art forms to construct trauma narratives

o Creating the trauma narrative will help to decrease severity of symptoms

Session 8

• Goal/Focus
  
o In-vivo exposure to desensitize clients to trauma triggers
  
o Therapists will work with clients to face triggers in session, so that clients have a safe place to process the triggers
  
o Clients will also have the option of sharing trauma narratives with each other

Session 9

• Goal/Focus
  
o Preparation for conjoint parent-child session
  
o Therapists meet with parents/caregivers alone, to prepare them for the sharing of clients’ trauma narratives
  
o Therapists will also meet with clients, to prepare them for sharing trauma narratives with caregivers/parents

Session 10

• Goal/Focus
  
o Conjoint parent-child session
  
o Clients will disclose trauma to parents/caregivers, utilizing their trauma narratives
Parents/caregivers will have a chance to respond to the trauma narratives, in a supportive manner

Session 11

• Goal/Focus
  o Enhancing future safety and development
  o Therapist will assess for concerns of safety, and provide an open space for clients to express concerns
  o Clients will share experiences of sharing trauma narratives with parents/caregivers
  o Termination preparation

Session 12

• Goal/Focus
  o Termination
  o To prepare clients and caregivers for termination
  o Graduation ceremony
  o To setup aftercare plan
  o To reflect upon group members’ progress
Summary

The goal of this project is to create a clinical tool, to help therapists provide adequate treatment for children who have experienced emotional and physical abuse in the home. While there is a variety of applicable interventions for treating children who have experienced trauma, the group setting presented in this project, provides clinicians with a new apparatus for treating this population. This project combines the EBP, TF-CBT, with other common psychotherapy techniques and interventions. The end result is a session-by-session breakdown, equipped with instructions, a schedule, guidelines, and handouts, while still allowing room for the therapist’s clinical creativity.

Discussion

The concept of my project evolved from ideas and experiences, stemming from my time in the classroom and at my clinical field site. As therapists, we have a legal and ethical obligation to report any suspected child abuse. This reality of the job became clearer, when I began working at Strength United, a DCFS contracted agency. There, all of my clients were court-mandated due to having open child abuse reports with the county. While I had the opportunity to work with different types of people who held different experiences, for the most part, there was one common theme; trauma. The form of my clients’ trauma usually involved some sort of emotional or physical child abuse. Witnessing the effects of trauma on the children, as well as the parents, including the offending parents, sent me on an unfamiliar journey, which consumed the last 2
years of my program. I accompanied my clients on their individual journeys, as they battled with understanding their situations and processing severe traumas, many of which had been ongoing for some time. These beautiful, challenging experiences, which make up my clients’ stories, are testaments to the strength that I have witnessed in individuals who have lived through unthinkable situations. While some of my cases may have closed without meeting their specific goals, or did not have the happy ending I expected, the majority of my clients have transcended trauma and expressed extreme gratitude for the impact therapy has had on them. These are the small moments when a formerly “resistant” client makes even the slightest change, and the gift of hope is instilled. These are the moments when a client who has terminated therapy several months ago, calls to share all of the positive things, which have occurred since their last session. These are the small moments when a child’s eyes light up, because they feel understood and supported. These are the moments that kept me going and continue to keep me going when I am feeling overwhelmed, overworked, and underappreciated.

While holding onto these moments, and conjuring up possible ideas for my culminating experience, I knew my project had to embody my experience as a beginning clinician. Much like my clients’ stories, my experience has been equally beautiful and challenging, pushing me to my limits and making me grow in areas, which I did not know needed growth. Thus, it was a given that my project be trauma-focused, as my entire clinical experience throughout this program has been.

I combined the knowledge I learned from my coursework, and the importance of EBPs, to make a tool, that I as a clinician would want to use. Especially with groups, it can be a daunting task to lead a bunch of clients, without having a template to go off of. With the theory to back up my project, I manipulated the section of the trauma narrative to include art
interventions, to feed my internal hunger for art. For me, it made the process of creating my project more personal, as art is a very important part of my life, and a part that I often struggle to incorporate into my clinical practice.

When deciding the age of the participants for my group, I knew that I wanted to create a therapy group for children. While I had a wonderful experience leading an adult group at my field site, it got me thinking about the need for a children’s group to process trauma. At my field site, there are different groups to aid adults with this task, however, there aren’t any groups available to children. In my experience, it has become apparent that adult groups are more accessible and common. It got me thinking about the power of the group, and how children could benefit from the group process just as much, if not more than their parents who were already enrolled in group therapy. Furthermore, most of my work experience has been with children, so it seemed fitting that I create a project suited for this population.

**Future Work**

It is my hope that other clinicians will find my project valuable and easy to implement into clinical practice. I tried my best to create a user-friendly guide, for this reason. I also tried my best to maintain a balance of structure, while still leaving room for clinical creativity. To further nurture the development of my project, I could:

- Run this group at my future place of employment, under direct clinical supervision
- Advocate in the community for the importance of children to have a safe place to process trauma, and the benefits of therapy
- Continue to advance my project and work towards publication
References


Appendix

The Curriculum

Overview

Art Therapy Group for Child Survivors of Abusive Homes is a 12-week therapy group designed to help children cope with and process the feelings, thoughts, and behaviors associated with the trauma of experiencing physical and emotional abuse. Each session will last 1.5 hours and will include participation of the client and the client’s caregiver(s). This can be used as a clinical guide for therapists to facilitate a group with clients who have fallen victim to the epidemic that is child abuse. Utilizing the EBP TF-CBT, therapists can implement a well-researched theory to help young clients begin the healing process. The combination of TF-CBT and art interventions provides a mix of effective treatment, which can also serve as a creative outlet for clients.

Materials

- Large work table, chairs
- Paper, construction paper, pencils, erasers, glue, scissors
- Paint, paintbrushes, paint palettes, paint canvases, water glasses to clean brushes
- Paper towels
- Empty, blank boxes (cardboard, or wood)
- Magazines
- Device to play music on
Assessment Process

The assessment process should take place prior to the onset of the group as a preliminary screening process. Ideally, the facilitators should aim to have all assessments completed 1-2 weeks before the group start date. The facilitators will initiate the assessment and the client intake, during which emergency contact and general information will be collected. Facilitators should meet in person with caregivers to complete the assessment/intake process. If possible, the assessment process should be done in a face-to-face interview so that the facilitators can ask follow up questions as deemed relevant. Facilitators can also use this time to explain the goal and format of the group as well as answer any questions that caregivers may have. A good tool for assessing childhood trauma is the Trauma Symptom Checklist for Young Children (Briere, 2005). There is also an example of a client intake, for facilitators to reference. Facilitators may use this example, or can use a client intake form from their agency/place of employment.
Agency Name

CLIENT INTAKE

Client’s Name: _______________________________ Date: _________________

Last First MI

Parent’s Name: _______________________________

Last First MI

Address: _______________________________

Cell Phone: _______________________________

Other Phone: _______________________________

PARENT’S INFORMATION (parent/caregiver who is participating in group)

Date of Birth (Month, Day, Year): _________________ Age: __________

Female ☐ Male ☐

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: __________

CLIENT’S INFORMATION

Date of Birth (Month, Day, Year): _________________ Age: __________

Female ☐ Male ☐

Mother’s Name: ___________________________ Father’s Name: ___________________________

School: ___________________________ Grade: ___

Please indicate who has legal and physical custody of the client.

Legal ___________________________ Physical ___________________________

Who lives in the home with child (list names, relationship, and ages)? ___________________________

____________________________

INSURANCE INFORMATION (facilitator should make copy of insurance card)

Insurance Company/policy number: ___________________________

EMERGENCY CONTACT INFORMATION
In case of an emergency, please contact:

Name: ___________________________ Relationship: ___________________________ Phone: ___________________________

Name: ___________________________ Relationship: ___________________________ Phone: ___________________________

Name: ___________________________ Relationship: ___________________________ Phone: ___________________________
Session Breakdown

Session 1

Introduction: 30 minutes

The goal of the first session is to provide clients and caregivers with knowledge of how the group works. First, the facilitators will give a detailed description of the group’s goal. This will help to provide clients and caregivers with motivation and hope for overcoming the experienced trauma. After making sure that the group is the appropriate fit, facilitators will initiate the informed consent with parents and clients. On the following page, there is an example of an informed consent. However, facilitators should use their agency’s personal informed consent when implementing this group. Facilitators will go over the limits of confidentiality and the instances where confidentiality must be broken. Since this is a group for children who have already experienced physical and emotional abuse, it is important to make sure that both caregivers and clients have an understanding of what is reportable.

Facilitators will explain the format of the group detailing expectations, requirements, and topics to be covered. Facilitators will explain that this is a closed group and that once the group begins, members are not allowed to join late. Parents and clients will be informed of the 15-minute late policy, which will prevent clients from disrupting the group process by coming to session late. Parents and clients will also be informed of the maximum 2-session absence policy. This will also help to decrease the amount of group disruption and help to weed out any clients who are not committed to the group. After everyone has an understanding of the limits of
confidentiality and group policies, facilitators will take time to allow for any questions that clients or their caregivers may hold.

**Group Rules/Explanation: 15 minutes**

At this point in the session, caregivers will be asked to leave and clients will continue on in the group. Facilitators will start by establishing some group rules to ensure that participants feel safe and respected in the group. The group rules include no interrupting, no name-calling, listening to other members share, and responding to group members in a respectful fashion. This should be an interactive way of establishing rules. Facilitators should post a piece of paper and write the rules out as they are explaining them. Facilitators should ask participants what rules they would like to have for the group. This will begin to establish a collaborative relationship between group members and facilitators. Facilitators should also take time to explain why the children are in this group. It is important to cover this again, without caregivers present as many children might feel uncomfortable disclosing in front of their caregivers, especially if the caregiver present is the abuser. Facilitators should explain that everyone is in the group because they have had a similar experience. Facilitators can also make this portion interactive, asking participants why they believe they are present in the group.

**Break: 5 minutes**

**Icebreakers: 30 minutes**

Facilitators will lead the participants in a simple icebreaker to start off. Facilitators will ask clients to share their name, age, and a hobby. Facilitators will also participate in this exercise, by leading with the same information. This icebreaker can be done in a circle or by volunteer
basis. Facilitators should be sensitive and aware of participants’ comfort levels in sharing. Different participants may feel more comfortable than others. Participants should not be forced to participate if they do not wish to.

The second icebreaker is called “Two Truths and a Lie”. Participants will share three things about themselves. Two of those things will be true while one will be a lie. After each person shares, the other group members will have to guess which one is a lie. Facilitators should participate in this exercise as well by also sharing two truths and a lie, in addition to joining in the fun of guessing participants’ lies. This exercise will help group members to get to know each other in a fun way. Facilitators should print out flashcard templates on next page, to help implement this exercise.

**Closing: 10 minutes**

As a closing exercise, facilitators will lead group members in an activity called “My Wish”. For this exercise, facilitators will hand out small post-its to each group member. Group members will then be asked to write one wish that they have for themselves, in regards to expectations/hopes for this group. Clients will have the options of sharing their wish aloud, or, posting it on a giant heart poster, which will be hanging on the wall. This exercise will conclude the first session of the group.
Session 1-Informed Consent

Agency Name
Art Therapy for Child Survivors of Abusive Homes
Group Contract and Consent to Treat

Instructions
Dear parents/caregivers, please read the following information and initial each box indicating you have read the presented material. If there is any section that you do not understand or is unclear, please ask the group facilitator/therapist for further clarification. Once you have read and initialed each section please print, sign, and date on the last page.

Consent to Treatment

☐ I the undersigned parent/legal guardian, consent to, and authorize ________________________________ (facilitator/therapist) and (agency name) to provide all therapeutic and psychological services that may be deemed advisable or necessary for my child, as apart of the Art Therapy for Child Survivors of Abusive Homes therapy group.

☐ I acknowledge and understand that in order for my child to participate in the Art Therapy for Child Survivors of Abusive Homes therapy group, I consent to my physical participation in the group as explained by the group facilitator/therapist.

☐ This consent will remain in effect for the duration of my child’s participation in the Art Therapy for Child Survivors of Abusive Homes group.

☐ I acknowledge and accept that the group facilitator of facilitators assigned to lead Art Therapy for Child Survivors of Abusive Homes group may be a therapist trainee or intern with the unofficial title of “therapist” and as such will discuss my child’s concerns and issues with a licensed clinical supervisor in either a group or individual setting.

☐ I acknowledge and accept that it is my responsibility to remain in contact with the group facilitator/s to discuss my child’s goals, needs, and progress.

☐ I/we acknowledge and accept that while many people find counseling/psychotherapy to be very helpful, I/we and/or individual family members may feel worse before starting to feel better.

Confidentiality and Privilege

☐ I acknowledge and accept that (agency name) and (facilitator's name) will not discuss any information regarding my child, myself, and services received, without my oral and written permission via a 2-way release.

☐ I acknowledge and accept that the group facilitator will keep weekly records of my child’s progress.

☐ I acknowledge and accept that (agency name) and ________________________________ (therapist/facilitator) will adhere to the standards of confidentiality and privilege defined by ethical counseling practice.

☐ I acknowledge and accept that there are some exceptions to confidentiality and privilege, which arise from certain California legal and ethical mandates and that as a mandated reporter, the group facilitator is under legal and ethical obligations to report any of the following:

  • The obligation of reporting to authorities without the client’s consent any suspicion of abuse, endangerment or neglect, either physical or sexual, of any child, elder, or dependent adult.
  • The duty to warn the intended victim and the authorities when it appears that the client or a person known to the client intends to hurt another person.
  • The need to take appropriate steps to prevent an attempt when it appears evident that the client will most probably make a suicide attempt.
  • When disclosure is required pursuant legal proceeding.

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In each of the above instances, an effort will be made to inform the parent/caregiver that a report or disclosure will be made. The parent/caregiver will also be encouraged to make any report to authorities themselves.

### Cost of Services

I acknowledge and accept that the weekly fee for my child and myself to participate in Art Therapy for Child Survivors of Abusive Homes group is (insert agency's fee for group) and that my child could forfeit his/her place in the group if the fee is not paid.

### Appointment Timing and Cancellations

I acknowledge and accept that it is my responsibility to attend and to make sure my child is present each week for the scheduled group session time.

I acknowledge and accept that each group session is 1 hour and 50 minutes in length, and begins at the appointed time. Sessions will begin at the set session time and will not start late for any reason. I acknowledge and accept that there is a strict 15-minute late policy and understand that my child will not be allowed to join the group after 15 minutes past the session start time.

I acknowledge and accept that if there are more than two absences without giving any notice and receiving permission from the facilitator, this may cause immediate termination of services.

I acknowledge and accept that it is my responsibility to have a working telephone number in order for (agency name) and the (facilitator’s name) to contact me.

I acknowledge and accept that any time I need to cancel, reschedule, or makeup an appointment I will directly contact the group facilitator at least 24 hours in advance.

### Contacting My Therapist

I understand that if I need to cancel, reschedule, or speak with my child’s therapist regarding a non-urgent matter, I should call the facilitator/therapist at: _________________. My child’s facilitator/therapist will attempt to call me back as soon as possible, although this may not be immediately.

I agree that, in a life-threatening emergency, I will contact 911 and not my child’s therapist.

### Agreement

Each of the undersigned acknowledges that he/she has read and understands the forgoing provisions and that the person signing as agent, parent, or personal representative, certifies that he/she is lawfully entitled to act on behalf of the client.

I have read, initialed, and signed each of the above terms and conditions, with full understanding and agreement of the above terms.

**NOTE:** In accordance with Fam. Code § 6924 and Health & Saf. Code § 124260, a minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis in certain circumstances.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Client Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Caregiver Name</td>
<td>Parent/Caregiver Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Therapist Name</td>
<td>Therapist Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

[ ] Trainee  [ ] Intern  [ ] Licensed
Session 1-Two Truths and a Lie Icebreaker

Can you guess my lie?!

1. ______________________
2. ______________________
3. ______________________
Session 2

Psychoeducation & Parenting: 30 minutes

The first portion of this session will be done with just the caregivers. The group facilitators will cover psychoeducation of trauma, including the effects of trauma, symptoms of trauma, negative coping mechanisms or behaviors associated with trauma, and effective treatment. This will help to bring awareness to caregivers, and help them begin to understand how trauma has affected their child. Additionally, facilitators will provide caregivers with psychoeducation regarding child development for this age group, as well as developmentally appropriate responses. Group facilitators should be mindful of caregivers’ knowledge and education levels, allowing time for questions and process, as needed.

Psychoeducation for Group Members: 20 minutes

The rest of this session will be conducted with just the group members. Facilitators will provide clients with age appropriate psychoeducation, explaining and defining trauma, and its effects. This section will set the tone for the rest of the group, guiding clients towards the goal of processing trauma.

Identification of Trauma Themes: 30 minutes

Facilitators will lead group members in identifying trauma themes. Trauma themes can be single words, phrases, sentences, or pictures, which the client identifies as relevant to their trauma experience. Facilitators can initiate this exercise by posing questions such as: “What feelings come up when you think of the abuse?” What did you see? “What did you hear? “What were you thinking?” Group members should be given blank pieces of paper, markers, paint,
magazines, scissors, glue, and other art materials to help create their trauma themes page. Facilitators can put on some soft music to help provide a calm and safe environment for clients to work. While clients are working, facilitators should be scanning the room and offer guidance when necessary. Beginning to acknowledge trauma can be difficult for clients, so facilitators must be aware of how each client reacting to creating their trauma themes page.

Closing: 10 minutes

Facilitators should lead an open discussion, inviting clients to share their experience of creating the trauma theme page. This can include sharing the actual trauma theme page, or sharing what thoughts and feelings came up for clients, while work on the art exercise. Facilitators should use the trauma theme page as a tool to help clients feel more comfortable disclosing trauma.
Session 3

Explanation: 20 minutes

First, facilitators should begin the session by explaining what relaxation techniques are. Facilitators can express the feelings that are associated with trauma, such as anxiety, fears, anger, depression, and share with clients that all of these feelings are normal reactions to the trauma that clients have experienced. Facilitators should express that sometimes these feelings can be overwhelming, and explain that there are tools to help cope with these feelings. Facilitators should make this portion interactive by encouraging clients to share feelings they hold, related to the trauma.

Relaxation Exercise 1: 15 minutes

Facilitators will walk clients through a series of relaxation techniques, to help clients learn new skills to manage symptoms of depression and anxiety stemming from trauma. The first relaxation technique is called “Spaghetti”. This is intended to be a “silly” technique, which will allow clients to feel more comfortable learning relaxation techniques, a concept which may be new to them. Facilitators should use voice and physical demonstration to lead clients through this exercise. Facilitators should have fun with this exercise, to model that relaxation techniques are supposed to be a positive experience. Group members will stand up from their seats, preferably in the center of the room, away from any furniture. Facilitators will ask clients to stand in a hard spaghetti position, tensing up all of their body parts. After holding this position for a couple minutes, clients will then be asked to fall into a soft spaghetti position, where their body parts can fall limp. Facilitators should encourage clients to imagine what a piece of hard, pre-cooked spaghetti looks like, and what spaghetti looks like after it’s cooked, to help align their bodies
accordingly. Facilitators can walk clients through this exercise a couple of times, having them hold each position longer than the previous time.

Relaxation Exercise 2: 15 minutes

After the first relaxation exercise, clients should take a seat before beginning the second exercise. Facilitators will walk clients through a deep, abdominal breathing exercise. Clients should place a hand on their abdomen, as they slowly breathe in and out. This will help clients to monitor the rise and fall of their breath. Facilitators can walk clients through this exercise, and then allow clients to continue on their own. Facilitators can play soft music in the background, to help clients relax.

Break: 10 minutes

Discussion: 30 minutes

Facilitators will lead clients in a discussion of both relaxation exercises. Clients will be encouraged to share what their experiences were like, as well as how they felt before the exercise, during the exercise, and after the exercise. Facilitators will then lead discussion of what other relaxation techniques or coping mechanisms clients use as outlets. This will help clients to acknowledge strengths they already poses, as well as discover new possibilities for coping mechanisms. Clients will be encouraged to link unwanted feelings to positive coping mechanisms, to help educate clients on what they can do to reduce symptoms. Clients will be encouraged to utilize coping mechanisms outside of therapy.
Session 4

Psychoeducation: 10 minutes

Facilitators should provide clients with psychoeducation regarding the importance of identifying and expressing emotion.

Feelings Game: 20 minutes

To help clients begin to disclose feelings about the trauma, facilitators should start with the “Feelings Game”. The game will help to make clients feel more comfortable, and to learn that expressing oneself can be fun. The game will help clients to identify an express feelings unrelated to the trauma first, before moving towards the goal of disclosing about the trauma. Facilitators will have clients take turns picking cards from the pile, and sharing what is being asked of them. Facilitators should participate in the game, by picking cards and disclosing. Use flash cards on next page to facilitate identification and expression of feelings. Facilitators can also add to flash cards, by creating similar questions.

Break: 10 minutes

Identification & Appropriate Expression of Emotion: 45 minutes

Facilitators will then lead a discussion, to help clients identify, express, and process feelings of guilt, shame, sadness, fear, and anger, related to the trauma. Clients will be encouraged to share specific experiences of trauma and the relevant feelings. The facilitators are to listen empathically and help clients to process feelings. Clients will be able to listen to other group members share, as well as respond to what other group members have been through.
### Session 4: Feelings Game

<table>
<thead>
<tr>
<th>Describe a time when you felt sad. How did you feel? What did you think?</th>
<th>Think if time that you felt embarrassed. What happened for you to feel this way? How did you handle the situation?</th>
<th>Describe a time when someone close to you hurt your feelings. What did you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share a time that you hurt a friend’s feelings. How did you feel? What did you do?</td>
<td>What makes you feel angry?</td>
<td>What do you do when you get mad?</td>
</tr>
<tr>
<td>Show the group your “disgusted” face.</td>
<td>What makes you laugh?</td>
<td>What do you do when you feel sad?</td>
</tr>
<tr>
<td>Describe a person in your life, who makes you feel loved.</td>
<td>Share a time that you felt lonely.</td>
<td>Describe a time that you felt scared.</td>
</tr>
</tbody>
</table>
Share a time when someone surprised you.

Show the group your “silliest” face!

Describe a time when you couldn’t stop laughing.

How do you feel when you get in trouble at school?

What happens when you don’t follow the rules?

Describe a time that you felt proud of yourself.

Describe a time that your parent expressed feeling proud of you.

How do you feel when someone close to you is sad?

How do you feel when someone close to you is mad?

What do you do when you feel scared?

How often do you express your feelings to others?

How do you feel today? Why do you feel ______?
Session 5

Psychoeducation: 20 minutes

Facilitators will provide clients with psychoeducation regarding positive coping techniques and maladaptive coping techniques. Facilitators should use examples of both types of coping techniques, to help paint a clear picture for clients. Psychoeducation should be done in a group discussion format, to help make this portion of the session more interactive.

Maladaptive Coping Techniques Exercise: 30 minutes

Clients will be asked to think of their own maladaptive coping techniques, and portray a picture of what this looks like. Clients can use pencils, markers, paint, and other art materials to create this exercise.

Break: 10 minutes

Cognitive Coping & Processing: 30 minutes

Facilitators will help clients to connect thoughts and feelings related to trauma, to maladaptive coping techniques. This will help to bring awareness of this relationship to clients. Facilitators will also help clients to explore more positive coping techniques, for when clients experience negative thoughts and feelings related to trauma. Clients will have the opportunity to identify existing positive coping techniques, as well as establish new ones. Facilitators’ goal is to help clients become aware of strengths, and encourage them to implement these existing coping mechanisms, in place of maladaptive coping techniques. This portion should be facilitated by group discussion.
Session 6

Creating Trauma Narratives: 35 minutes

Clients will work on creating individual trauma narratives detailing thoughts, feelings, behaviors, and experiences related to the trauma. The narrative serves as a way for clients to tell their stories, while processing the trauma, which has occurred. Clients may experience negative feelings or reactions to this process, so group facilitators should be aware of each client’s needs, and intervene when necessary. Clients will have the option of writing a poem, writing a song, writing a book, making a comic book, creating a drawing, creating a painting, or any other art modality to create their trauma narratives.

Break: 10 minutes

Creating Trauma Narratives: 30 minutes

After the break, clients will continue working on their trauma narratives.

Closing: 15 minutes

Facilitators will lead group members in discussion, regarding creation of trauma narratives. This will allow clients the space to disclose/express any feelings, which may have come up while working on their narratives.
Session 7

Creating Trauma Narratives: 35 minutes

Clients will continue working on their trauma narratives during this session. Facilitators should be attuned to clients’ reactions, during this process. Facilitators should spend time with each client, to help offer support during this process.

Break: 10 minutes

Creating Trauma Narratives: 30 minutes

Clients will continue finishing up their trauma narratives. This will be the last opportunity to complete the narratives.

Closing: 15 minutes

Facilitators will lead clients in a group discussion, where clients can disclose feelings regarding entire process of creating trauma narratives.

Session 8

Sharing Trauma Narratives: 45 minutes

Clients will take turns sharing their trauma narratives. Clients will go through the process of disclosing what the narrative means, feelings/thoughts/behaviors associated with trauma, and process of creating the trauma narrative. Facilitators will help to lead discussion, as well as help clients to process feelings regarding trauma and trauma narratives.
Break: 10 minutes

Facing Triggers: 35 minutes

Clients will disclose trauma triggers to the group. Facilitators will aid clients in addressing these triggers. Facilitators will help clients to identify triggers, and to role-play possible scenarios, where triggers may occur. Facilitators will help clients to brainstorm solutions and positive coping techniques to utilize, when triggers do occur.

Session 9

Preparing Caregivers for Conjoint Session: 45 minutes

For the first half of this session, facilitators will meet with parents and caregivers alone, to help prepare them for the upcoming joint session. Facilitators will explain what the trauma narrative is, and the process their children went through in creating it. Facilitators will explain how difficult the conjoint sessions may be for parents to hear their child explain the abuse they have endured. The sessions may be especially difficult for the perpetrating parents, as well as the non-offending parents, who may feel a responsibility for not protecting their child. Facilitators will lead caregivers in a discussion, to provide caregivers the opportunity to express thoughts, feelings, and concerns, regarding the upcoming conjoint session.

Preparing Clients for Conjoint Session: 45 minutes

For the second half of the session, facilitators will meet with clients alone, to help prepare them for the upcoming conjoint session with their caregivers. Facilitators will explain the benefits of sharing their trauma narratives with their parents, as well as the ultimate goal of
creating stronger relationships with their parents. Facilitators will encourage clients to share their narratives during the conjoint session, but will express that clients are not obligated to share, if they do not feel comfortable or ready. Facilitators will lead clients in a discussion, in which clients can disclose thoughts, feelings, and fears, regarding sharing clients’ trauma narratives with their parents.

Session 10

Introduction: 10 minutes

Facilitators will preface this session with a brief introduction, explaining the goal of this conjoint session, and reminding parents and clients that it may be difficult to hear the trauma narratives. Facilitators will also set guidelines for caregivers when responding to clients’ narratives, encouraging caregivers to respond in a supportive manner, that validates clients’ experiences and feelings.

Sharing Trauma Narratives: 35 minutes

Clients will begin sharing their trauma narratives with the group. Clients will explain their art piece, as well as experience of trauma. Clients will disclose thoughts, feelings, and behaviors associated with the trauma. Directly after a client discloses, the client’s caregiver will have the opportunity to respond. Caregivers should address clients’ experiences, thoughts, and feelings, regarding the experienced trauma. Caregivers may also use this as an opportunity to apologize for their role in the abuse.

Break: 10 minutes
Sharing Trauma Narratives: 35 minutes

Clients will continue to share their trauma narratives, while having the opportunity to confront caregivers. This will continue for the rest of the session, until each client who wants to share, has had the opportunity to share.

Session 11

Follow-up: 30 minutes

Facilitators will lead a discussion, to allow clients the space to process last week’s conjoint session. Clients will have the opportunity to disclose their experiences of sharing their trauma narratives with their caregivers.

Enhancing Safety: 20 minutes

Facilitators will assess for clients’ sense of safety. Facilitators will lead a group discussion, in which clients have the opportunity to disclose fears concerning possibility of future abuse. Facilitators will help clients to identify positive coping mechanisms, and encourage them to use these tools when they feel stressed.

Break: 10 minutes

Termination Preparation & Making Toolboxes: 30 minutes

Facilitators will prepare clients for the termination session the following week. Clients will disclose thoughts, feelings, and concerns about group ending. Group facilitators will reflect upon clients’ progress in the group, skills acquired, and clients’ strengths. Clients will begin
working on toolboxes, to fill with tools to help cope with feelings related to trauma. Clients will be given blank, empty boxes, to decorate and fill with tools.

Session 12

Toolboxes & Maintenance: 30 minutes

Facilitators and clients will discuss clients’ plan for maintenance/aftercare. Clients will continue to decorate their toolboxes, and share tools, which will be added their toolboxes. Facilitators should also provide items for clients to fill their toolboxes with. Possible items could include Play-Doh or clay, markers, a journal, stickers, a stuffed animal, etc. Facilitators and clients will discuss the potential for future situations, in which clients may feel a range of negative emotions. Clients will be encouraged to refer to their toolboxes to help cope when they experience these situations.

Yarn Exercise: 30 minutes

Facilitators will lead clients in a group activity. Facilitators will need a ball of yarn to implement this intervention. Facilitators will have clients sit in a circle, and encourage each client to share something they have gained/learned from being in this group. After clients have shared, they will then pick one person to share a positive quality about and pass the ball of yarn to that person, while still holding on to their portion of the yarn. The client who receives the yarn will share, and the process will be repeated until each member has shared. Facilitators should also participate in this exercise. Eventually, the yarn will create a web, covering the middle of the circle. Clients can cut pieces of the yarn to make themselves bracelets to wear.
Graduation Ceremony: 30 minutes

Parents will be invited to join the rest of the session, during which the graduation ceremony will take place. Facilitators will provide caregivers with information regarding aftercare and maintenance. Clients will be awarded with certificates of completion. Facilitators will call up each client one-by-one, and hand out the certificates. Clients should share a reflection of progress for each client, as they receive their certificates. Clients will have the option of sharing something that they have learned, with the entire group. On the following page, there is a template for the certificates. Facilitators can plug applicable information into this template.
Certificate of Achievement

awarded to

for

[Signature]

date