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Hidden Homelessness: A Trauma-informed Narrative Approach to Treating Rural Families Facing Homelessness

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Contents

Abstract

Housing is a crucial part of survival and one's ability to engage in life. There is an increasing population of both individuals and families who live without safe, quality, stable housing. Housing insecurity is a concern in both urban and rural areas, with rural homelessness presenting unique characteristics and challenges. To better understand rural homelessness and its effect on families, research was conducted on many factors including: population statistics, characteristics and common issues, problems, risk factors, engagement, terminology, and frameworks. It becomes evident that homelessness has severe implications physically, emotionally, and mentally for both children and adults. This synthesis of research will be important in better understanding homelessness and the population it affects for the purpose of developing an evidence-based family practice curriculum.

Rural Homelessness Literature Review

Statistics about the population

Homelessness is not limited to any certain demographic, life experience, or geographic location. People facing housing insecurity come from backgrounds of every kind, and each story is unique and personal. America is seen as a wealthy and developed country, yet homelessness is an increasingly present problem. In January 2020, there were 580,466 people experiencing homelessness on streets and in shelters across America (National Alliance to End Homelessness, 2022). This number is likely to be greater, with rural and secluded areas making it harder to collect data. Homelessness is not an individual problem; families make up 30% of the homeless population (National Alliance to End Homelessness, 2022). Within these families, 2.5 million children are homeless each year in America, creating a historic high of one in every 30 children in the U.S (American Institute for Research, 2022).

Homelessness is not just a reality in the downtown streets of big cities. Alarmingly, one in three rural Americans say homelessness is a problem in their community (Meehan, 2019). Although it may not always present itself as people standing on corners holding signs for food or money, the problem does exist. In the 2018 homelessness assessment report from the Department of Housing and Urban Development, it was found that a greater portion of people facing homelessness in rural settings are unsheltered as compared to the suburban and urban homeless population (Meehan, 2019). It is also concerning that the highest rate of growth for student homelessness in recent years has been in rural America (Meehan, 2019). One rural resident talked about the lack of resources in rural communities like shelters or established outreach systems, which makes counting the rural homeless population a challenge (Meehan, 2019). This

implies that these already concerning numbers might be lower than the reality rural communities are facing.

The likelihood of being homeless is tied to gender, race, and ethnicity. In terms of gender, males are far more likely to experience homelessness than their female counterparts; out of every 10,000 males, 27 are homeless, and this number is 13 for women (National Alliance to End Homelessness, 2022). Gender disparities become even more glaringly evident when the focus is solely on individual adults. Historically, marginalized groups are more likely to be disadvantaged with housing, similar to many areas of American life. Although white people are the most represented racial group in the homeless population, historically marginalized racial and ethnic groups are, proportionally, far more likely to experience homelessness (National Alliance to End Homelessness, 2022). The reasons for this are many and varied but tend to fall somewhere in the umbrellas of racism and caste. Native Hawaiians and other Pacific Islanders have the highest rate of homelessness (109 out of every 10,000 people), and Native Americans (45 out of every 10,000) and Black or African Americans (52 out of every 10,000 people) also experience elevated rates (National Alliance to End Homelessness). It is important to note that these rates are much higher than the nation's overall rate of homelessness (18 out of every 10,000) (National Alliance to End Homelessness, 2022).

Characteristics and common issues

There are unique characteristics and common challenges faced by people experiencing homelessness in a rural setting versus an urban setting. The rural setting has changed throughout the years. Certain social problems stereotypical of urban settings have emerged like poverty, adult and youth homelessness, increasing crime rates, drug addiction, and minority-majority group conflicts (National Health Care for the Homeless Council, 2013). These social problems

don’t magically appear; there are significant factors at play. Some of the trends that have altered the culture of rural communities include: corporate takeovers of family farms, restructuring of industries, in-migration of ethnically-diverse populations, out-migration of young people, and rising average of the rural population (National Health Care for the Homeless Council, 2013).

These trends have changed rural communities, but there are other factors significantly contributing to the rise in homelessness. Some of these factors include: lack of affordable housing, prevalence of low-wage service occupations, lack of infrastructure to support employment (child care and transportation), inadequate treatment opportunities for medical and behavioral health problems, natural disaster, and domestic violence (National Health Care for the Homeless Council, 2013).

There are certain patterns often seen in rural homelessness. Individuals will often search out housing for extended amounts of time and eventually settle for substandard living conditions. Common places of residence include a very limited number of shelters, doubling up with friends and family, severely substandard structures that would be condemned in urban areas, couch surfing, outdoor locations, vehicles, and abandoned buildings (National Health Care for the Homeless Council, 2013). These locations would not be considered stable, quality housing. For some cultures, it is normal to double up with housing, however, overcrowded living situations are associated with domestic violence and child abuse (National Health Care for the Homeless Council, 2013). For those residing in less visible places, such as a hidden vehicle or an outdoor location, it may be a conscious decision to remain hidden from abusers, parents, creditors, or police (National Health Care for the Homeless Council, 2013). Housing insecurity in rural settings is far from homogenous.

It must be acknowledged that there is an inability to identify and quantify the full population. There are three main causes for this phenomenon. First, the rural landscape often camouflages homelessness through expansive geography with low population density (National Health Care for the Homeless Council, 2013). Second, unstably housed individuals reside in less visible locations than in urban areas (National Health Care for the Homeless Council, 2013.) Third, cultural norms deny that homelessness can exist in the idealized rural setting and aim to rid communities of the social problem (National Health Care for the Homeless Council, 2013). This is a considerable difference between urban and rural homelessness.

There are certain structural barriers in place that restrict access to, and prohibit provision of, services. The following barriers are more specific to rural homelessness: a limited number of homeless-specific services; lack of institutional capacity and staff; provider shortages, limited shelter beds; lack of affordable housing; large service areas; dispersed populations; lack of public transportation; lack of outreach to engage individuals in services; individuals' reluctance to seek outside assistance; and individuals' desire for privacy (National Health Care for the Homeless Council, 2013). Something not often thought about is the rural social structures and attitudes towards homelessness. Negative attitudes towards the problem can influence community responses between the extremes of marginalization and generosity, which creates resource-rich and resource-poor rural areas (National Health Care for the Homeless Council, 2013).

Risk factors

Early life experiences greatly influence outcomes later on in life, and this is specifically true when it comes to homelessness. There are many risk factors that feed into the outcome of homelessness, but it is important to note that culture has a large influence on these risk factors. A major risk factor for homelessness is negative childhood experiences. Risk is especially high for

those that experience limited contact with family before age 18 (Czaderny, 2020). Having an incomplete or troubled family in adolescence can seriously impact the long-term outcomes of ones life, having an influence on both educational and professional choices. This can lead to the removal of an individual from and can lead to early removal from one's family residence; thus, having both indirect and direct effects on the prevalence of homelessness (Czaderny, 2020). A lack of loving care, neglect and adoption are also linked to homelessness, but less strongly than other factors (Czaderny, 2020). Other risk factors include school expulsion, lack of academic qualifications, poor social networks, and antisocial and offending behaviors (including experiences in prison) (Shelton et al., 2015). Childhood adversity in its various forms is significantly associated with homelessness among young adults, as well as economic disadvantage, mental illness, and recent drug use (Shelton et al., 2015). "Up to 50% of homeless and runaway adolescents may have experienced physical abuse; almost one-third reported experiencing sexual abuse" (Shelton et al., 2015). Furthermore, adverse financial situations before the age of 18 have been associated with homelessness (Shelton et al., 2015). The research shows that home/family life during development as well as educational achievement are two significant risk factors.

Major concerns or problems for this population

The concerns accompanied with being homeless are abundant. The most common problem experienced by those facing housing insecurity is deteriorating health. Common health problems experienced by homeless people are HIV/AIDS, lung disease like bronchitis, tuberculosis, and pneumonia, malnutrition, mental health problems, substance use problems, wounds and skin infections (MedlinePlus, 2021). People who are homeless die on average 12 years sooner than the general U.S. population (National Healthcare for the Homeless Council,

2019). It is a vicious cycle; poor health not only comes from homelessness but also creates it. Health problems cause an employment problem due to missing work, exhausting sick leave, or not being able to maintain work functions. Without money to pay for health care, one may not be able to heal and work again. If an illness does not heal over time, it can be difficult to regain employment and without income from work, an injury or illness quickly becomes a housing problem. Savings are exhausted and one can't rely on friends forever. According to the National Healthcare for the Homeless Council, "Simply being without a home is a dangerous health condition" (2019). This can be seen in the lack of safe places to store medication and the inability to maintaining a healthy diet in soup kitchens and shelters where meals are often high in salt, starch and sugars (National Healthcare for the Homeless Council, 2019). The most coordinated medical services are not effective if the patient's health is continually compromised by unhealthy living conditions. No amount of health care can substitute for stable housing (National Healthcare for the Homeless Council, 2019).

Homelessness within families, comes with its own set of concerns. Family homelessness is strongly linked to domestic violence and 91% of homeless mothers have experienced severe physical and/or sexual abuse during their lifetimes (Institute for Children, Poverty, & Families, 2013). The power and control present in abusive relationships can lead to isolation and financial dependency, which are especially detrimental for those with already limited incomes and poor credit histories (Institute for Children, Poverty, & Families, 2013). Without social and economic support, survivors are left with few housing options. A Minnesota study revealed that nearly one in three women listed domestic violence as a primary reason for their homelessness and almost half reported staying in abusive relationships because they had nowhere to go (Institute for Children, Poverty, & Families, 2013). These statistics weigh heavily not only on the couple but

also on the entire family, including the children. Children in homeless families also suffer greatly because of domestic violence and each year, approximately 15.5 million children are exposed to domestic violence (Institute for Children, Poverty, & Families, 2013). This creates adverse childhood experiences for these children and creates potential for a perpetual cycle of abuse and homelessness.

When experiencing homelessness, there is a greater chance of experiencing food insecurity. This can have detrimental effects on children, as their brains and bodies are developing and has been shown to worsen physical health, mental health and academic performance, and create developmental delays (Institute for Children, Poverty, & Families, 2013). Even when food is purchased, it is often not of quality or nutritional value. With limitations in income and access to nutritious food, many end up eating diets high in fat, cholesterol, and sugar (Institute for Children, Poverty, & Families, 2013). The lack of a nutritional diet of children negatively affects classroom performance and can also contribute to developmental delays, behavioral issues, and mental and emotional health issues (Institute for Children, Poverty, & Families, 2013).

Homelessness also contributes to alcohol and drug use concerns. This is a major concern for the homeless population because substance abuse issues can create complications in one's ability to seek care for other health issues (Institute for Children, Poverty, & families Families). For those living in poverty or experiencing homelessness drugs and alcohol often become coping mechanisms. Homeless mothers have a higher lifetime rate of substance abuse than that of housed low-income mothers (41.1% versus 34.7%) which is twice that of women in the general population (Institute for Children, Poverty, & Families, 2013). This problem is very difficult to address because there is a shortage of comprehensive residential treatment programs for mothers

with children. Parental substance abuse is a contributing factor for between one and two thirds of children in the child welfare system (Institute for Children, Poverty, & Families, 2013).

Engagement

Homelessness in a rural setting is much different from that of an urban setting. Several different dynamics of the rural setting create difficulty in the engagement of the homeless population. One challenge of engaging the rural homeless population is a lack of awareness of the issue. In urban settings, the homeless population is often found on the streets. However, the diverse landscape of many rural settings causes the homeless population to be more hidden. Not only are those without homes harder to see in rural settings, but those with unstable housing are often pushed to the outskirts of rural towns, where they are less noticeable. These factors have fed into a cultural belief that denies the existence of this issue in rural settings (*Institute for Children, Poverty and Families*, 2013).

Not only is this population hard to identify in rural settings, it is also difficult to get resources to this population once they are identified. Because this is a widely accepted problem in urban settings, there are a number of homeless-specific services provided. In rural settings, this is not the case. Not only is there a lack of homeless-specific resources available but research has found a lack of affordable housing. The population density of rural areas is much less dense than that of urban settings, and public transportation is not readily available. These gaps in resources mean there are not only limited resources for those experiencing homelessness, but there are also many barriers in receiving the resources that are available. In a setting where there is a limited number of resources specifically for the homeless population, a collaboration of resources could possibly be used to get this population the help that they need, but research has

also found a lack of collaboration between resources in rural settings (*United States Government Accountability Office*, 2010).

Not only is this problem unacknowledged by local communities, but research on it is also hard to come by. Sampling methods used in urban settings are much less effective than those used in urban settings. For example, counting the number of people receiving homeless resources is an effective way to measure homelessness in urban settings where there are readily available. This method becomes less effective in rural settings when there is a lack of resources available. Other methods have tried to apply the data of urban settings to a rural setting and this is also not effective (*Institution for Children, Poverty, and Families*, 2013*).* There has been a positive feedback loop created, where there are not quality services for the rural homeless community because there is a complete lack of resources. The combination of the lack of resources, along with other external factors, have made it very difficult to gather information on this population.

Terminology

There is a lack of consistency of terminology used for the rural homeless population that has created a barrier for gathering research and creating resources. One term that has inconsistency within government agencies is “homelessness”. Some agencies define homelessness more literally and only include those that are on the streets. Others have adopted definitions that include children and youth in substandard housing. And others have a definition that include those that are “doubled-up” (a term that refers to families who are temporarily living in an alternative household) (*United States Government accountability office*, 2010).

A second term that must be defined in order to address the problem of rural homelessness is “rural.” There is inconsistency in defining this term across different federal agencies. Different

agencies use different criteria such as a population threshold or proximity to urban areas (*United States Government Accountability Office, 2010).* While most definitions are focused on population size (usually bellow 20,000 people), others are focused on being "rural in character". Others focus on the amount of mortgage credit for low to middle-income families. This inconsistency has caused very similar communities to be defined in different ways, and has excluded some from being considered rural and receiving needed resources (*United States Government Accountability Office, 2004).*

Frameworks

The above research goes to show that this is a very complex issue that includes not only the homeless individual but also his or her environment. For this reason, it is believed that systems theory should be applied when addressing the rural homeless population in the United States. System theory is based on the idea that human behavior is not individualistic but is heavily influenced by the context and systems of the individual. In the above research, it was found that the landscape (*Institution for Children, Families, and poverty*, 2013), cultural norms (*Institution for Children, Families, and poverty*, 2013) (*United States Government Accountability Office, 2010),* available resources (*United States Government Accountability Office, 2010),* healthcare (*National Council for Homeless People*, 2013), and many other factors, contribute to this issue of homelessness. Homelessness is not a matter of people willingly choosing not to get jobs or housing, but rather a systematic issue with many facets.

A study done on homelessness in rural Canada found that "the social structure contributed to rural homelessness," and "barriers to securing rental housing in a tight market were influenced by small-town dynamics and discrimination" (Buck-McFadyen, 2022). What

makes this even more complicated is that each rural setting has its own set of systems that comes with its own set of unique challenges (U.S. Department of Housing and Urban Development, 2018). For this reason, each rural setting must consider their own communities' systems as well as the federal systems in place, in order to address the issue more effectively.

Research Informed Practice: Article Summaries

APA Citation

Armstrong, J. M., Owens, C. R., & Haskett, M. E. (2021). Effects of a Brief Parenting Intervention In Shelters For Mothers And Their Children Experiencing Homelessness. *Journal of Child and Family Studies, 30*(9), 2097-2107. https://doi.org/10.1007/s10826-021-02021-2

Introduction

This study was done to examine the effects of parenting intervention on the outcomes of both parents and children in homeless shelters. The intervention looked at the Positive Parenting Program or Triple-P program. This intervention targets parents to improve parenting and enhance outcomes of children.

Procedures and Descriptions

The intervention has been previously studied and been shown to have positive outcomes but this was the first study done in a homeless shelter setting. The specific intervention

performed in this study used focus groups for parents with children ages 2-6. The focus groups had focused on specific topics and were available as options by all participants in the study. The study found positive outcomes for both parents and children.

Findings

The study found that the brief intervention improved child behavior and parenting practices, but it did not cause any decrease in risk of child abuse.

Conclusion

It was concluded from this study that the intervention seems to be effective in this setting but further research needs to be done to determine if the intervention is effective for fathers, as this study only included mothers. I believe this is an effective and important intervention for families in homeless shelters.

APA Citation

Bender, K., Begun, S., DePrince, A., Haffejee, B., Brown, S., Hathaway, J., & Schau, N. (2015). Mindfulness Intervention with Homeless Youth. *Journal of the Society for Social Work and Research*, *6*(4), 491–513. https://doi.org/10.1086/684107

Introduction

This study was done to test the effectiveness of mindfulness interventions on homeless youth. The study used the SAFE intervention on a group of homeless youth ages 18-25. This intervention was applied through 3-day skills-based group training.

Procedures and Descriptions

The SAFE intervention was originally designed to treat victimized youth and with the knowledge that many homeless youths are victimized it was modified to fit this population. In this study a 3-day group mindfulness training was performed, and the effects on the youth were then analyzed. The analysis looked for outcomes in the participants but also looked for what was effective in generating participation and what were roadblocks for participation.

Findings

It was found that after the 3-day intervention there was a significant improvement in the youth's observational skills as well as their general mindfulness skills. Although there was not long-lasting improvement in every skill analyzed, the intervention being only 3-days long could point for the need for a less brief intervention. The study analyzed the effectiveness of the intervention but it also looked at what techniques were effective in engaging the youth and what identified engagement barriers. Techniques that were found to be helpful were facilitated interactions, personal sharing of challenges, teaching concepts, and peer activation. The challenges to this study included the prioritization of basic needs, a fight or flight instinct, and a general distrust.

Conclusion

The authors concluded that this had potential to be an effective intervention for homeless youth but more research needed to be done to prove its effectiveness, especially on a more long-term scale.

APA Citation

Cunningham, M., & Batko, S. (2018, October). *Rapid re-housing's role in - urban institute*. Urban Institute. Retrieved October 21, 2022, from https://www.urban.org/sites/default/files/publication/99153/rapid_re-housings_role_in_responding_to_homelessness_3.pdf

Introduction

This study is an analysis of rapid re-housing as an intervention to homelessness. This intervention uses short-term financial services, case management, and housing search services to find new homes for the homeless population as soon as possible.

Procedures and Description

This study is a review of previous research done on rapid re-housing. Although their is not a large body of research on this program because it is fairly new, this review summarizes what is known about this intervention.

Findings

The review showed that there is evidence of it being effective. At the end of the program 70% of families found permanent housing, and income increased by 34-38% for those who participated. This program was also found to be cost effective as the average monthly cost per family was 82% lower than the monthly cost per family for shelters.

Conclusion

This article concludes that the intervention is both cost effective and effective in outcomes. The article also called for more research and believes that we still have a lot more to learn about this intervention.

APA Citation

Ponka, D., Agbata, E., Kendall, C., Stergiopoulos, V., Mendonca, O., Magwood, O., Saad, A., Larson, B., Sun, A. H., Arya, N., Hannigan, T., Thavorn, K., Andermann, A., Tugwell, P., & Pottie, K. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. *PLOS ONE, 15*(4). https://doi.org/10.1371/journal.pone.0230896

Introduction

This study is a review of the effectiveness of Standard Case Management (SCM). This is an intervention that includes a case manager who facilitates the family's situation helping them gain access to healthcare and social services. This form of intervention has been shown effective for many valuable populations but its use with the homeless population does not have a very big body of evidence.

Procedures and Description

This review also looked at alternations of this intervention including, Intensive Case Management, Assertive Community Treatment, and Critical Time Interventions. This was a review of trials done on the effectiveness of standard case management. The review analyzed a number of outcomes including, housing stability, mental health, quality of life, substance use, hospitalization, income and employment, and cost-effectiveness.

Findings

In the SCM trials reviewed ten out of eleven showed a decrease in homelessness. Some studies showed improved quality of life, improved mental health and improved employment situation but these were not consistent findings across studies. One consistency found across these trials was that the effectiveness of the intervention faded with time, and long-term intervention was necessary to make real change.

Conclusions

The researchers concluded from this study that for this type of intervention to be effective it needed to be continued, community based and intensive.

APA Citation

Shinn, M., Samuels, J., Fischer, S. N., Thompkins, A., & Fowler, P. J. (2015). Longitudinal Impact of a Family Critical Time Intervention on Children in High-Risk Families Experiencing Homelessness: A Randomized Trial. *American Journal of Community Psychology*, *56*(3-4). https://doi.org/10.1007/s10464-015-9742-y

Introduction

The purpose of this study was to highlight how Family Critical Time Intervention (FCTI), a community-based service model for families living in homeless shelters, has the ability to improve mental health and school outcomes specifically for children experiencing homelessness. FCTI combines housing and structured, time-limited case management to families leaving the shelter with community services. The study compares the effects of FCTI to usual care for

children in 200 newly homeless families whose mother had a diagnosable mental illness or substance problem.

Procedures or Description

This study was part of a larger experiment taking place in the homeless shelter system in Westchester County, NY, and to be eligible, mothers had to have a diagnosable mental illness or substance abuse problem while also caring for at least one child aged 1.5-16 years. 200 families were included in the comparison of FCTI treatment and usual care conditions, most of which identified as African American, unemployed, never married, and not currently living with a spouse or partner. Data was collected within 2 weeks of shelter entry as well as 3, 9, 15 and 24 months after. The measures included the following: internalizing and externalizing behaviors, depressive symptoms, school/child care attendance, positive school/child care attitudes and experiences, school/child care trouble, school effort and performance, teacher-related behavior and learning, negative life events, community integration, child separation, permanent housing, and parenting practices.

Findings

In regard to housing experience, families in the FCTI group spent 43% of the first 3 months after random assignment and 91% of the next 6 months in conventional housing within the community compared to 8% and 45% for families in the usual care group. Children and mothers in the FCTI group were shown to have reduced internalizing and externalizing behaviors. Fewer absences and more positive school experiences were reported in the FCTI group, as well as improved class performance and decreased school trouble. Although effects weren’t seen for most variables, the treatment differences favored the experimental group and occurred across different reporters, showing it wasn’t due to chance.

Conclusions

Although there were limitations to the study, it suggested that FCTI was effective in supporting families in which the mother had a diagnosable mental illness or substance problem by improving child outcomes directly and furthering broader improvements that happen over time.

APA Citation

Bennett A., Crosse, K., Ku, M., Edgar, N. E., Hodgson, A., & Hatcher, S. (2022). Interventions to treat post-traumatic stress disorder (PTSD) in vulnerably housed populations and trauma-informed care: A scoping review. *BMJ Open, 12.* https://doi.org/10.1136/bmjopen-2021-051079

Introduction

The purpose of this study was to identify and analyze interventions that target the treatment of PTSD in people who are vulnerably housed, as well as describing how the treatments have been delivered using trauma-informed care.

Procedures or Descriptions

The study was done by conducting a scoping review. Electronic database searches were conducted by a health librarian, and the search was peer reviewed following the Peer Review of Electronic Search Strategies guidelines. Included were published and unpublished primary research studies that reported qualitative, quantitative, mixed-methods and non-comparative methods that evaluated interventions looking to treat PTSD in adults who are vulnerably housed. There was a screening process in order to select studies, as well as charting the data based on intervention type. Important to notice, persons with lived experience were included in the design stage of the project but not included in the scoping review.

Findings

28 studies met the inclusion criteria, and most studies were conducted in the US. Two research questions were considered including the interventions described in the literature for the specific population and whether any of those interventions were trauma-informed. Four studies were identified that explicitly stated using a trauma-informed approach when providing treatment.

Conclusions

Unfortunately, this study shows the need for more evidence on how trauma-informed care for PTSD in the vulnerably housed should be delivered and its effectiveness. Compared to trauma-informed interventions, the non-trauma focused therapies were generally ineffective with regard to PTSD symptoms. There are gaps in providing trauma-informed care to vulnerable populations, like vulnerably housed families. At the same time, there is no information pointing to the ineffectiveness of trauma-informed care, so it should still be utilized.

APA Citation

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services. *The Open Health Services and Policy Journal, 3*(80-100).

Introduction

The purpose of this article is to acknowledge the effectiveness of Trauma-Informed Care (TIC) within homeless service settings by exploring the evidence base with a review of qualitive and quantitative studies, along with other literature. Historically, there has not been enough attention paid to the trauma surrounding homelessness, but providers are recognizing the opportunity to respond to both immediate needs and longer-term healing of homeless

individuals. Homelessness is a traumatic experience in itself while also exposing an individual to additional traumatic events.

Procedures or Description

Included in this review of evidence is peer-reviewed qualitative and quantitative studies, as well as corroborative literature. Because there is more literature on TIC with mental health and substance use fields, evidence from these two fields were also utilized as there is large overlap with the difficulties faced. Organizational needs assessments were conducted with several agencies to detect gaps within systems and evidence of trauma-informed care was reviewed. Several paths for further exploration were discovered during the review of evidence. Information was collected from the field surrounding current theories, practices, programming, and policy initiatives. After implementing a TIC model within a service system, an organizational self-assessment can be conducted.

Findings

The review of evidence shows that Trauma Informed Care appears to be effective, despite the various challenges of implementation. TIC seems to be viewed positively by consumers and providers, it most likely leads to better outcomes, and the cost is not significantly more than usual treatment. Despite the promising evidence thus far, there is not enough research to date that evaluates the effectiveness of trauma-informed care specifically within homeless service settings. There has been increased awareness of the impact of trauma, but the implementation of trauma-informed care within homeless services is still in early stages.

Conclusion

Overall, the evidence suggests that solving the issues of homelessness will not be attainable without addressing the underlying trauma that is intertwined with the experience of homelessness.

APA Citation

SAMHSA. (2013). *Studies back trauma-informed approaches in homeless services.* SAMHSA https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/studies-backtraumainformedapproaches#:~:text=Studies%20Back%20Trauma%2Dinformed%20Approaches%20in%20Homeless%20ServicesMain%20page%20content&text=The%20study%20found%20that%20homeless,having%20experienced%20multiple%20traumatic%20events.

Introduction

The purpose of this article is to display how research backs the need for trauma-informed approaches in homeless services. The study, Service and Housing Interventions for Families in Transition (SHIFT), was discussed among several health and human service providers, researchers, government officials, and community members.

Procedures or Description

This study was conducted in the upstate cities of New York including Albany, Syracuse, Rochester, and Buffalo by the National Center on Family Homelessness. The subjects of the study were mothers in emergency shelters, transitional housing, and permanent supportive housing programs. These women were interviewed three times over a 30-month period.

Findings

The results of the study were alarming, finding that 93% of the participants had a history of trauma. 81% experienced multiple traumatic events, and about half the women met criteria for post-traumatic stress disorder. The majority of the women met criteria for major depression, and most were survivors of interpersonal violence. The children were also affected by the mother's trauma, as 41% had physical or emotional difficulties at the beginning of the study.

Conclusions

First, these results show that homeless mothers specifically are a "highly traumatized and under-served group". Second, this study shows that trauma is a significant result of homelessness and cannot be ignored in attempts to better one's circumstances. It is shown that unresolved trauma issues and low self-esteem were the only predictors of continuing residential instability at 30 months into the study. There is a critical need for services to learn about trauma and implement trauma-informed approaches. The justification of doing so is found within the people being served.

Family Treatment Curriculum: Rural Homeless Families

Theoretical Orientation

This curriculum uses a theoretical orientation of trauma-informed care. Trauma-informed care can be defined as 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" (Hopper et al., 2010). TIC supports the delivery of Trauma-

Specific Services (TSS), which are designed to directly address the impact of trauma, with the goals of decreasing symptoms and facilitating recovery (Hopper, et al., 2010). While TIC is the overarching framework that "emphasizes the impact of trauma and that guides the general organization and behavior of an entire system", TSS are the specific treatments for mental disorders resulting from trauma (Hopper et al., 2010). Focuses of trauma informed care include: trauma awareness, emphasis on safety, opportunities to rebuild control, and a strengths-based approach.

Within the trauma-informed care approach, this curriculum utilizes narrative therapy. The process of narrative therapy involves separating the person from the problem, critically examining the assumptions that inform how the person evaluates himself/herself and his/her life (Gehart, 2016). Through the process of narrative therapy, clients are able to identify alternative ways to see the world in which they live in. Narrative therapists assume that all people are resourceful, holding strengths and capabilities to better their situation (Gehart, 2016). The client is never the problem. Rather, the problem is the problem and is imposed upon people by unhelpful or harmful societal practices and broken systems (Gehart, 2016).

The use of narrative therapy coincides with a trauma-informed care approach by allowing the client to be the expert of their circumstance, working to rebuild a sense of control. The combination of these approaches allows for an overall sense of safety, an environment where the client doesn't feel blame, an opportunity to take control of the narrative, and a focus on the strengths and resources possessed by the client.

Goals and Outcomes

The overarching goal of this curriculum is to empower the clients and assist them in creating the capacity to address many of the problems being faced as a homeless family. There are three main ways that this curriculum is designed to meet this overarching goal: (1) address and provide treatment for anxiety and stress; (2) address and provide treatment for past trauma and (3) equip and strengthen the parental role. By acknowledging these three areas, the client will be able to move forward with an empowered mindset, addressing the physical and emotional needs that arise.

Techniques and Methods

The goals and outcomes will be attained through narrative therapy techniques, while keeping in mind trauma-informed care principles. There will be assessments given to the client for trauma, stress, and anxiety. To reduce anxiety and stress, as well as learn coping strategies, mindfulness practices will be carried out either at the beginning or end of each session. To help the client find their voice, the therapist will perform a technique called “re-storying” which allows the client to make meaning and find purpose in their experience (Ackerman, 2017). The therapist will facilitate the externalization technique, which helps the client view problems and behaviors as external from themselves (Ackerman, 2017). The Unique Outcomes technique will be utilized to allow the client to change their storyline, fostering hope and optimism for the future (Ackerman, 2017).

Regarding questioning, intentional questions will be utilized more than internal state questions in order to promote a sense of agency. The therapist will ask for the client’s permission before asking questions that could be taboo or make the client uncomfortable. The

therapist will work to situate comments by revealing the source of their perspective, emphasizing that it is only one perspective. In doing so, the client will be less likely to over privilege the comment. At the end of the treatment, the therapist will utilize therapeutic letter writing and write a letter to the client based on the position they have taken in relation to developing a preferred story. The letter will serve to reinforce the strengths and possibility of the life-affirming story that has been created. There will be a definitional ceremony at the end of the therapeutic relationship in order to solidify the preferred narrative that has been developed.

Family Dynamics

Rural homelessness within the context of a family creates an array of dynamics, many of which are trauma-inducing. A social worker using narrative therapy should understand the specific perspective that each family has on their situation, but research done on rural homelessness can provide specific dynamics for the social worker to identify. Rural homelessness presents itself very differently than homelessness seen in urban settings and is not socially accepted as an issue in many rural communities, causing many people who are homeless to go unnoticed for an extended period of time. There is a lack of resources such as homeless shelters in rural settings. Although doubling up with housing is common in some rural settings, it can also be problematic, causing unsafe housing conditions and putting the family at higher risk for domestic violence and child abuse. The lack of support for rural homeless families can leave a family facing homelessness with an abundant feeling of hopelessness that mast be overcome in the therapeutic setting.

The state of homelessness is a source of stress in and of itself, but is also connected with other stressors such as health concerns, physical abuse, and sexual abuse. The health of a

homeless family is likely to be of concern. Homeless families are at a greater risk of experiencing and being exposed to violence within the living situation. Both poor health and exposure to violence create trauma and mental health struggles. The devastating results of homelessness can also be the reason families become homeless; it is a vicious cycle. The therapist must be aware that each family's path to homelessness looks vastly different.

The statistics on stress and trauma-inducing events faced by homeless families are alarming. When performing narrative therapy with the homeless population, it is important to listen to how the family members frame these different traumas that have been faced. With the large amounts of abuse and challenges likely experienced, families will likely feel unseen, powerless, and stuck in their current situation. The first goal of the therapist is to listen and understand the dynamics of the family, their story and their perspective of both of these. The second goal is then to improve their perspective of their story and their situation. This change does not happen by manipulating the circumstances of the family but rather by having them reframe their experiences, separating themselves from the problem. In doing so, the families can disrupt the harmful thinking patterns possessed and feel empowered to work together and make positive changes moving forward.

Roles

The social worker is focused on the client's mental stability and well-being, as well as the parental role. Other services like housing search and case management are being offered by other providers. The role of the social worker is to search for an alternative way of understanding/describing the client's narrative. The social worker will act as a non-directive collaborator, treating the client as expert of their own story and not imposing judgements or

opinion (Clarke, 2022). The social worker takes on a curious and investigative disposition, a not-knowing stance, in the therapeutic relationship, more interested in the client's perception of the cause instead of the cause of the problem. Because of the joint process of constructing meaning, the social worker can be thought of as coauthor or coeditor while the client is the author.

Treatment Plan

This form will be reviewed again in no more than two months, and progress toward goals will be noted. Changes in interventions or goals should be noted immediately.

Identified Client(s) : 30 (Emily), 13year-old daughter (Olivia)

Clinic Record: N/A **Number Insurance**: N/A

Diagnosis: N/A **Summary of Client's Concerns: Anxiety and stress, as well as trauma, resulting from homelessness, along with connection to daughter**

Identified Patient Strengths and Resources (to be added to throughout therapy): Resilience, willingness to listen, hopefulness, motherly instincts, thoughtful

Interview Progress Narrative

Long-Term Goal: Empower client to establish the mental and emotional capacity in order to take the next step in establishing a stable living environment for herself and her children.

Problem/Concern #1: Crippling anxiety and stress		
Objective	**Intervention**	**Progress Towards Goal**
Unpack current and past experiences with anxiety and stress.	Ground and Centering Exercise (Week 1) Anxiety Assessment (Week 1)	

Identify causes of anxiety and stress. Assess levels of anxiety and stress with psychological tests. Increase understanding of anxious feelings and emotions. Effective and healthy coping mechanisms will be adopted. <u>Target Date:</u> <u>Completion Date:</u>	Stress Assessment (Week 1) Your Very Best (Week 1) Mindfulness Bell Exercise (Week 2) Come Back (Week 2) Deep Breathing for Relaxation (week 3) Mindfulness Water Drop Activity (Week 4) Safe place Visualization (Week 5) Positive Affirmations Activity (Week 6)	
Problem/Concern #2: Lack of parenting skills/feeling withdrawn from children		
Explore feelings and needs of both parent and children Enhance parental communication and attending skills Increase occurrences of parental praise Create and enforce clear rules and boundaries from parent to child Strengthen attachment between children and parent through bonding exercises <u>Target Date:</u>	Provide Parenting Education Resources (Week 4) Family Attachment Narrative Therapy Activity (Week 4) Strengths and Virtue Survey Discussion (week 4) Education Parent-Child bond (Week 5) Parent Writing Letter to Child (Week 6)	

Completion Date:		
Problem/Concern #3: Trauma from homelessness		
Assess trauma with psychological tests. Increase understanding of what trauma is and its impact. Separate problem from person Develop a preferred narrative	Trauma Assessment (Week 1) Trauma is More Than an Event Education (Week 2) Narrative Therapy Education (Week 2) My Life's Story Worksheet (Week 2) Externalization Education (Week 3) Relative influence Questions (Week 3) Strengths and Virtues Survey (Week 4) Unique Outcome Technique (Week 5) Letter to Client (Week 6) Definitional Ceremony (Week 6)	

Signature: _____ Date: _____

Patient signature:_____ Date: _____

Structure of Curriculum:

Week 1:

Goals/Objectives:	Meeting the person apart from the problem • Gain trust and build rapport • Learn about the client's life • Assess level of trauma and anxiety/stress • Name and identify problem and contributing factors
Purpose of the Session:	The purpose of this session is to begin a trusting foundation for the helping relationship, building strong rapport with the client. Collaborative goals will be formed between client and therapist. The client will be given assessments to complete. Narrative therapy will be introduced, making clear that the client's story and interpretation are essential. Who the client is apart from their situation will be explored. The therapist will learn about the client and his or her life, such as hobbies, interests, relationships, etc. The factors that contribute to the problem with be identified.
Checklist of Items:	White board markers Trauma assessment • For adult: Structured Trauma-Related Experiences & Symptoms Scanner (STRESS) • For child: Child and Adolescent Trauma Screen (7-17 years) Anxiety assessment • For adult: GAD-7 • For child: Spence Children's Anxiety Scale – Child Stress assessment • For adult: Perceived Stress Scale • For child: Perceived Stress Scale – Children
Breathe In:	Ground and Centering exercise: 1. Find a comfortable and quiet space to do this exercise, maybe taking off your shoes if you feel comfortable. 2. Stand up and start by just feeling your feet on the ground, connected to the earth beneath you. 3. Draw your attention to the springiness and stiff sensations in your legs. 4. You may want to imagine as if you were a tree, rooted with your feet in the earth and legs strongly connected. 5. Start shifting your weight from one side to the other, swaying gently like a tree in the breeze. 6. Shift your weight from front to back.

	7. As you shift your weight, bring awareness to your center of gravity, located in the upper pelvic area and below the navel. 8. Bring your hands on top of your lower belly and feel your center. 9. Continue to sway from side to side and front and back while keeping the hands on top of your lower belly.
Education:	The social worker will introduce their role in the relationship and the layout of the treatment plan. The purpose of the assessment tools will be explained. The purpose of narrative therapy will be briefly introduced (further psychoeducation will take place next session).
Intervention / Activity:	The parent and child will take time to complete the trauma, anxiety, and stress assessments towards the beginning of the session. Draw out a tree of life on board (both adult and child work together) • Roots: significant figures from ancestry, origins, and family history • Trunk: significant events that have shaped their lives, either positive or difficult • Leaves: important people or significant relationships • Branches: thoughts, ideas, wishes about desired direction in life • Fruits: achievements accomplished • Bugs: problems and challenges in day to day life
Breathe Out:	Homework: Your Very Best • Write a 300-word introduction describing yourself at your very best • The introduction should have a beginning, middle and end. • It could be about one concrete moment in time, not a collection of multiple occasions. • It must be written in a positive tone. • Encourage the client to review the story regularly and reflect on the strengths identified

Week 2:

Goals/Objectives:	Re-storying and putting together a narrative • Allow client's to be expert of experience

	• Bring meaning to challenges • Gain perspective • Introduce an alternative to narrative
Purpose of the Session:	The purpose of this session is to give the client a voice to tell their story in their own words. It will be imperative for the client to be the expert of their circumstance and in bringing meaning to the problems faced. The client will explore their experiences deeper and find alterations to their narrative.
Checklist of Items:	Worksheet Pens
Breathe In:	Mindfulness Bell Exercise video found at: (https://positivepsychology.com/mindfulness-exercises-techniques-activities/) Discuss the "Your Very Best" homework: • What strengths does this story illustrate? • Do you use this strength often? • Do the strengths and values present in the story you told show up in different areas of your life? • How can you make these strengths more prominent in your everyday life?
Education:	Discuss what trauma is and how it can impact one's life: TRAUMA IS MORE THAN AN EVENT • Trauma is an **experience**. A traumatic event is an experience of physical sensations and psychological disruptions. The brain assigns meaning to the experience and labels the memory accordingly. This process is unique to every person, which is why an event may be traumatic to one person, but not to another. • Trauma has an **effect**. Experiencing a traumatic event has adverse effects on the mind and body. These biological reactions may occur immediately or may be delayed, and the duration may be short term or long term. The individual may not recognize the connection between the traumatic event and the effects, but the effects are a critical component of the trauma. Dive deeper into what narrative therapy involves and why the use of narrative is so powerful in healing from trauma. Go over narrative therapy principles. Print off worksheet for clients to look

	at. • Narrative therapy is a style of therapy that helps people become – and embrace being – an expert in their own lives. In narrative therapy, there is an emphasis on the stories that you develop and carry with you through your life. From: • Principles include: 1) therapist influential, but decentered; 2) person separate from problem; 3) all problems have exceptions; 4) opposite of problem is preferred; 5) preferred story is woven into identity; 6) impact of relationships explored; 7) deconstruct societal norms; 8) personal decision making supported.
Intervention / Activity:	Completing the 'My Life Story' worksheet and discuss. • The goal with the My Life Story exercise is to begin creating emotional distance from the client's past so that you he or she can become reflective in order to gain perspective on life as a whole. This is a storytelling outline that helps organize life events and gain self-compassion, without going too deeply into the memories.
Breathe Out:	'Come Back' - When you catch yourself caught up in worries about the future or guilt and regret about the past, notice when it happens and simply and kindly say to yourself, "Come back". Then take a calming breath and focus on what you are doing right now.

Week 3:

Goals/Objectives:	Externalizing: Separating person from problem • Introduce externalization • Engage in interactive dialogue • Map out influence of problem and persons • Decrease unproductive blame and sense of failure
Purpose of the Session:	The purpose of this session is to begin the process of separating the person from the problem, fostering a sincere belief that the client is apart from his or her problem. The client will begin to acknowledge that the problem doesn't define every aspect of his or her life. An attitude of externalization will not be forced, but rather introduced as a way to think about the problem. Questions about how the

	problem has affected the person's life and relationships will be asked.
Checklist of Items:	White Board Markers
Breathe In:	Deep breathing for relaxation: 1. Sit back in a comfortable position. You can close your eyes. Try placing one hand on abdomen so you can feel it rise and fall with each breath. 2. Breathe in slowly through your nose. Time the inhale to last 4 seconds. It's fine to go even slower, if you prefer. 3. Hold the air within your lungs, but not to the point of strain. 4 seconds is a good target to aim for. 4. Pucker your lips, and slowly exhale through your mouth. Time the exhale to last 6 seconds. 5. Repeat the breathing cycle for at least 2 minutes. Practice for 5 to 10 minutes for greater benefits.
Psychoeducation:	Describe what externalization is and how it can be beneficial. The positive effects of externalization include: • Decreases unproductive conflict and blame between family members • Undermines sense of failure in relation to the problem by highlighting times the persons have had influence over it • Invites people to unite in a struggle against the problem and reduce its influence • Identifies new opportunities for reducing influence of the problem • Encourages a lighter, less stressed approach to interacting with the problem • Increases interactive dialogue rather than repetitive monologue about the problem
Intervention / Activity:	Relative influence questioning (Draw out on Whiteboard) • **Mapping the influence of the problem:**) How has the problem affected the clients at a physical, emotional, and psychological level? 2) How has the problem affected the clients' identify stories and what they tell themselves about their worth and who they are? 3) How has the problem affected clients' closest relationships: partner, children, parents? 4) How has the problem affected other relationships in clients' lives: friendships, social groups, work, or school colleagues? 5) How has the problem affected the health, identity, emotions and other relationships of significant people in clients' lives?

	• **Mapping the influence of persons:** 1) When have the persons involved kept the problem from affecting their mood or how they value themselves as people? 2) When have the persons involved kept the problem from allowing themselves to enjoy special and/or casual relationships to their lives? 3) When have the persons involved kept the problem from interrupting their work or school lives? 4) When have the persons involved been able to keep the problem from taking over when it was starting?
Breathe Out:	Have client take a picture of the whiteboard, and encourage them to view it frequently as a reminder that they are separate from the problems they are facing.

Week 4:

Goals/Objectives:	Finding strength and resilience • Learn coping strategies • Recognize strengths • Gain confidence in parenting ability • Create space for mother and child bonding
Purpose of the Session:	The purpose of this session is to establish strengths in both self and the client's external system. The client will learn how to cope with anxiety of stressful situations, as well as anxiety felt from trauma. The parent/child connection will be explored. The client will recognize strengths in their ability to parent well.
Checklist of Items:	Computer Paper Pens/Pencils
Breathe In:	Mindfulness Water Drop Activity 1. Take a second and make yourself comfortable with your feet flat on the ground and close your eyes. 2. Now take about five deep breaths and try to quiet your mind so that you are focusing on nothing but your breathing 3. Now I am going to have you imagine a water drop starting at the top of your head and running down your body very slowly. As it does I want you to focus on that section of your body. 4. Imagine the water droplet on your head: think of how your head protects your brain and all the valuable information

	that is in it. 5. Now imagine that the drop is running down your face, as it reaches your ears think of all that they have heard today and all that they have done for you and thank them for that. 6. As the drop goes down to your eyes think of all the beautiful things you have seen today and all the work your eyes have done for you and thank them for that. 7. As the drop goes down to your nose pay attention to what you smell right now be aware of your nose and its breathing. Thank it for all it has done for you today. 8. As the drop reaches your mouth relax your jaw and your lips. Think of all that your mouth has done for your today... breathing... eating... tasting. 9. As the drop goes over your neck, notice any tension that you have in your neck. Think of how your neck has supported your head throughout the day, and let it relax. 10. As you reach your shoulders think of all of the weight that your shoulders have taken on throughout the day. Notice any tension in your shoulders and try to relax them letting all the stress out. 11. As you reach your arms and your hands think of all the work that they have done let them relax and thank them for all their hard work. 12. Now bring your attention to your chest. Think of your ribs and how they are protecting your lungs. Notice any tension in your chest and let it relax. Focus on your breathing in and out and thank your lungs for all their hard work. 13. Now bring your attention to your back and notice any pain or tension in your back. Thank your back for all the weight it has held up throughout the day. 14. Bring your attention now to your stomach notice any comfortability stress or tension in your stomach. 15. Now focus on your legs. How do they feel? Do you have any tension in your legs. Thank your legs for all the hard work they have done allowing you to move today. 16. Now bring your attention down to your feet. Notice how they are feeling. Thank them for allowing you to do things today. Thank them for holding all of your weight. 17. Now that you are aware of your body, let us shift our attention to your emotions. What is it that you are feeling at this very moment (Pause for 30 seconds) 18. Now let us shift our attention to your thoughts. Be aware of your thoughts and let them drift by, allow them to keep moving along without stopping. (Pause for 1 minute) 19. Now at your own pace slowly bring yourself out of that space and open your eyes.

	20. How was that experience for you. What did you notice about yourself? How do you feel now Versus when you started this activity?
Education:	Provide Parenting Resources: - Tripple P Parenting Website: https://www.triplep-parenting.com/us/hot-parenting-topics/my-child/ (Free parenting resources and blog: good for general parenting information and education) - Parenting N Website: https://www.parentingni.org/resources/parenting-articles/ (Free parenting support and education) - Explanation of Narrative Therapy: https://www.verywellmind.com/narrative-therapy-4172956 (Although the general education on parenting is valuable, the parent can help make sessions more effective by reiterating narrative therapy at home.)
Intervention / Activity:	Family Attachment Narrative Therapy Activity Pt. 1: Child's Narrative • The child client is asked to write out a narrative of their life including: - Important events in their life - How they became homeless - The situation they are currently in - How they feel about this situation (Narrative can be written out in story form, in bullet points or in an alternative form that is preferable for the client and fitting for the clients age and ability) Have client take the VIA strengths and virtues survey (https://www.viacharacter.org/) and discuss the results. - Parent takes survey as the child writes the Narrative - Child takes survey as parent writes narrative for child Family Attachment Narrative Therapy Activity Pt. 2: Parent becomes the narrative therapist • Parental Client is asked to write an alternative narrative to the one that the child has already written. This Narrative puts the focus on: - The strengths of the Child - The parents love for the child - Growth moving forward (Parents Alternative narrative is written in the same form as the child in order to make a direct connection between the two) • Parent reads Narrative allowed and it is discussed between

	the Mother and daughter (The parent is the "therapist" in this situation in order to develop trust between parent and child. Actual therapist should use questioning to carry conversation and spark reframing if needed.) Discuss Strengths Virtues Survey (Both Child and Parent) • How are these strengths helpful in your current situation? • How are these strengths helpful in your parenting? • As the parent, how can you encourage _____ to focus more on their strengths?
Breathe Out:	Keep Alternative Narrative written by parent and have child hang it up somewhere it will be seen daily. As homework, complete the strengths wheel and encourage the client to hang it in a visible location where it will be seen every day.

Week 5:

Goals/Objectives:	Create Hope for the Future • Develop a life-affirming story • Foster optimism and hope • Use visualization to create image of possible future
Purpose of the Session:	The purpose of this session is to foster a sense of hope and optimism for what's to come in the client's future. This will be accomplished by developing a life-affirming story, or in other words, a preferred narrative. Unique outcomes with be explored, always with the client as expert of their story.
Checklist of Items:	Paper Markers Crayons
Breathe In:	The Safe Place Visualization (both child and adult participate): Utilize the Guided Imagery script from Dorset Healthcare to facilitate exercise, found at: http://www.dorsetpain.org.uk/Docs/Safe%20Place%20Guided%20Imagery.pdf) In addition to the guided imagery, ask clients if they would like to

	visualize their safe space by drawing it out on paper with markers and colors. In doing so, clients will have the ability to be reminded of their 'safe place" even after doing the exercise.
Education:	The Importance of the Parent-Child Relationship: • Young children who grow with a secure and healthy attachment to their parents stand a better chance of developing happy and content relationships with others in their life. • A child who has a secure relationship with parent learns to regulate emotions under stress and in difficult situations. • Promotes the child's mental, linguistic and emotional development. • Helps the child exhibit optimistic and confident social behaviors. • Healthy parent involvement and intervention in the child's day-to-day life lay the foundation for better social and academic skills. • A secure attachment leads to a healthy social, emotional, cognitive, and motivational development. Children also gain strong problem-solving skills when they have a positive relationship with their parents. Therapist asks clients about current practices they have that seem to build the child/parent relationship. Strengthening the Parent-Child Bond: • Tell your child you love them • Play together • Be Available (Set time aside for conversation with undivided attention) • Eat meals together • Listen and empathize • Spend one on one time with children (intentional) Therapist helps clients develop a plan: • Did any of these ideas stick out to you as a possibility? • Did this list spark another idea that is not on the list? • What is a good way that you could implement this into your life? • When? • What? • Where? • How long?

Intervention / Activity:	The unique outcome technique: a technique to change client's storyline and develop life-affirming stories (changing one's own storyline), a technique to develop life-affirming stories 1. The therapist asks clients about particular instances in which the client avoided being oppressed by the problem or prevented the problem from having a major negative influence on their lives. (Can you tell me about a time when you prevented this problem from oppressing you?) 2. Client is then invited to account for these unique outcomes and to redescribe themselves and their relationships with others in light of these exceptional events. (How did you manage to resist the influence of the problem on that occasion? What does this success in resisting the influence of the problem tell us about you as a person? What effect does this success in resisting the influence of the problem have on your relationship with your children?) Link new story to the past and extend into future: experience of experience questions may be used which invite clients to excavate forgotten or marginalized aspects of their experience or to imagine alternative ways of being that are consistent with their preferred self-story. Questions include: • If I were watching you earlier in your life, what do you think I would have seen that would have helped me to understand how you were able recently to achieve X? • What does this tell you and I about what you have wanted for your life? • If you were to keep these ideas in mind over the next while, how might they have an effect on your life? • Of all those people who know you, who might be best placed to throw light on how you developed these ideas and practices? • If you found yourself taking new steps towards your preferred view of yourself as a person, what would we see? • How would these actions confirm your preferred view of yourself? • What difference would this confirmation make to how you lived your life? Keep in mind...clients are the experts of their story. All explorations of the future are tentative rather than prescriptive. This requires the therapist to explore new possibilities tentatively using subjunctivizing language: • What if....

	• Could it be.... • Suppose you were to... • What would you...
Breathe Out:	Briefly explain what a definitional ceremony is and ask if the client would be interested in participating. Encourage the client to invite 3-4 people to be outsider witnesses at the definitional ceremony taking place next session. It would be most helpful is these people were close to the client, knew the client's situation well, or have experienced the situation themselves. Parent writing a letter to child • Goal: Solidify Child's emerging preferred narrative and identity • Involves: Parent will write a letter to the child, detailing the child's emerging story after the final session, emphasizing the child's strengths, taking an observer position of the changes the child is making, and highlight the temporality by speaking of where the child has been, where they are now, and where they are likely to go

Week 6:

Goals/Objectives:	Reflection and Celebration • Develop appreciation for the progress made • Reinforce and emphasize preferred narrative with outsider witness group present • Focus on strengths and resources • Effectively terminate therapeutic relationship
Purpose of the Session:	The purpose of this session is to reflect on the last 5 weeks, acknowledging how the client feels he or she has progressed. There will be celebration of the progress. The preferred narrative of the client will be emphasized and encouraged. In having a definitional ceremony with an outsider witness group, the ability for the client's new narrative to take root in the client's life will be enhanced. This session will contribute to an effective ending of the therapeutic relationship and transition into improved quality of life and functioning.
Checklist of Items:	Positive affirmation scripts for adult and child

	4 categories of response sheet for outsider witness group
Breathe In:	Positive affirmations are spoken together verbally for both the adult and child. The therapist should suggest moving to a body position of the power pose to increase confidence, but only if the client feels comfortable. The affirmations include: 1. I am worthy of love, happiness, and fulfillment. 2. I have the power within me to create the life I desire. 3. Each new day is filled with infinite potential and possibility. 4. I am so grateful for my life and all its blessings. 5. I forgive myself and hold myself in a state of compassion. 6. I love and accept myself just the way I am. 7. I am strong in my values and confident in my abilities. 8. I let go of the past and surrender concerns about the future. 9. I openly receive the experience of the present moment. 10. I continue to learn, grow, and evolve with each passing day. 11. I attract experiences that serve my highest good and facilitate persistent growth and transformation. 12. My life is filled with meaning, purpose, and passion 13. I have positive healthy, and supportive relationships with my loved ones. 14. I am confident in my talents, strengths, gifts, and abilities. 15. I have the courage and tenacity to overcome any challenge I face. 16. I freely give and receive unconditional love and acceptance to myself and others.
Education:	Explain the termination of therapy and how ending therapy can be a celebration of the progress made: “Ending therapy is a chance to close all of the doors you’ve opened during your time working on yourself. The process, whether short or long, will likely have shaken up the way you think, and that deserves your respect. Once we have experience something once, it is a lot easier to replicate it in other aspects of our life as opposed to trying to bring it about out of the blue with no help. A good ending might feel like a graduation, an acknowledgment and celebration of what is ending, with a view to what the future will bring.” Explain further in depth about the purpose of a definitional ceremony and what it will involve. Explain how the definitional ceremony will assist in the termination of therapy, along with its ability to solidify the preferred narrative that has been developed.

	• Definitional ceremonies involve collective self-definitions and the role of an audience or outsider witness; both parts are crucial • The process: The client will be interviewed about the ways in which they are trying to deal with whatever problems being faced. The outsider witnesses would act as an audience to this conversation. Next, the outsider witnesses would speak about what they heard the client speak about while the client is in the audience position. The roles would then be reversed again so that the client could reflect upon what had been spoken on by the outsider witness. • The 4 categories of response that outsider witnesses can contribute to rich story development: 1. Identifying the expression: As you listen to the stories of the lives of the people who are at the center of the definitional ceremony, which expressions caught your attention or captured your imagination? Which ones struck a chord for you? 2. Describing the image: What images of people's lives, of their identities, and of the world more generally, did these expressions evoke? What did these expressions suggest to you about these people's purposes, values, beliefs, hopes, dreams and commitments? 3. Embodying responses: What is it about your own life/work that accounts for why these expressions caught your attention or struck a chord for you? Do you have a sense of which aspects of your own experiences of life resonated with these expressions, and with the images evoked by these expressions? 4. Acknowledging transport: How have you been moved on account of being present to witness these expressions of life? Where has this experience taken you to, that you would not otherwise have arrived at, if you hadn't been present as an audience to this conversation? In what way have you become other than who you were on account of witnessing these expressions, and on account of responding to these stories in the way that you have? Script for therapist: (yy = person at the focus; zz = current state after growth of yy that invites a Re-membering Conversation, to be filled in before starting the Conversation; xx = the person they choose to re-

	member with. Three outsider witnesses are chosen before the activity starts.) 1. Re-membering Conversation a. Could you think of someone who's been in your life that wouldn't be surprised by [zz]? b. Can you tell me something that xx contributed to your life? What did they invite you to share in, to be part of? c. Could you say something about what xx appreciated about you that had them contributing these things to your life? d. Thinking back, what did you do to take in their appreciation? e. What do you think it contributed to xx's life that you were available for them to take an interest in and appreciate? How do you think xx's life was different for knowing you in the way that they did? f. What has it been like to talk, as we have been, about you and xx? Now please sit back and listen while I ask a series of questions of the listeners. 2. Outsider Witness Retelling a. What particular words or phrases struck you as yy was speaking? b. What images came to mind about what was important to yy? c. What is it about your life that meant these images came to mind? d. What has been confirmed for you by making this connection with what yy said? e. What difference will remembering this make in your own life? Finally, I'm going to ask yy a similar set of questions about what they heard. a. What particular words or phrases stood out for you? b. How are they connected to values that are significant for you? c. Does anything seem more possible for hearing these things? d. Can you describe what the first steps to take might be? e. What's it been like to talk as we have been? f. Is there anything more you want to say
Intervention / Activity:	Writing a letter to client • Goal: Solidify client's emerging preferred narrative and identity • Involves: Therapist will write a letter to the client, detailing the client's emergency story after the final session, emphasizing the client's agency, taking an observer position of the changes the client is making, and highlight the temporality by speaking of where the client has been,

	where they are now, and where they are likely to go • For further guidelines on therapeutic letter writing, visit: https://bcacc.ca/wp-content/uploads/2020/01/Therapeutic-Letters-in-the-Alleyways-Harkamal-Sangha.pdf Definitional Ceremony • Goal: to solidify the preferred narrative developed in the previous session • Involves: inviting significant others to the session in order for them to witness the new emerging story • Three phases: 1) The First Telling: client tells his/her story, highlighting the emerging stories as the invited witnesses listen; 2) Retelling: witnesses take turns retelling the story from their perspectives, prepared for the process by being asked to refrain from offering advice and judgements, and they are asked to situate their comments; 3) Retelling of the Retelling: the client retells the story incorporating aspects of the witnesses' stories
Breathe Out:	What I Will Take With Me: discuss the tools and skills the client will take with them following the series of successful therapy sessions which may include but is not limited to: coping strategies, positive affirmations, visualization techniques, mindfulness exercises, newfound support networks, progress made • Therapist will add thoughts regarding anything forgotten • May be helpful to provide the client with a summary of what was said

Suggested Resources/Supports

Additional resources and supports surrounding trauma, single motherhood, and coping with anxiety and depression will be provided for the family's continued healing after the last session of therapy. First, the client will be provided with contact info and information for a support group for single mothers.

Second, the client will be given names of recommended books for continued healing from trauma, including *What Happened To You* by Bruce D. Perry and Oprah Winfrey as well as *The Mindful Self-Compassion Workbook* by Kristin Neff and Christopher Germer. The client will

be provided with names of books for mother and child bonding, including *Mothering and Daughtering: Keeping Your Bond through the Teen Years* by Eliza Reynolds and Sil Reynolds as well as *The Intentional Family: Simple Rituals to Strengthen Family Ties* by William J. Doherty. Because of possible financial challenges, look for used versions or borrowing from others.

Third, the client will be introduced to and encouraged to download the iChill app on a phone, which was developed by the Trauma Resource Institute and takes clients through wellness skills of the Trauma Resiliency Model and the Community Resiliency Model. The client will be provided with a list of mindfulness and relaxation exercises, including the ones done in session. The client will be provided with name and contact information of local children's programming, which would allow client time for self-care and quiet reflection.

Transitions and Endings

An effective and healthy ending of the therapeutic relationship will require both therapist and clients to reach a mutual understanding that therapy has served its purpose and both parties feel significant progress has been made. First, the entire six weeks of therapy will be reflected upon by both client and therapist. The focus will be on how the clients feel progress has been made. Second, the therapist will explain the purpose of termination and how week six's activities contribute to the goal of a healthy ending. Third, there will be a definitional ceremony, which will assist in solidifying the preferred narrative of the clients and fostering confidence for life after therapy. This ceremony will involve inviting significant others of the client, or outsider witnesses, to witness the new emerging story. Fourth, the therapist will write a letter to the client. This letter will serve as a reminder and encourager to the client after therapy of the progress made and the detailed emerging story that has been developed. Finally, the therapist and client will discuss what the client will take with them from the therapeutic experience, including

discussion of coping strategies, positive affirmations, realizations made, newfound support systems, etc.

Methods for assessing outcomes

In order to assess the progress made with therapy, the same trauma, anxiety and stress assessments will be administered that were given in the beginning of the treatment process. Regarding trauma, the Structured Trauma-Related Experiences & Symptoms Scanner (STRESS) will be administered. For the child, the Child and Adolescent Trauma Screen (7-17 years) will be administered. Regarding anxiety, the GAD-7 will be administered to the adult and the Spence Children's Anxiety Scale – Child will be administered to the child. Regarding stress, the Perceived Stress Scale will be administered to the adult. For the child, the Perceived Stress Scale – Children will be administered.

Family Curriculum Outcome Reflection

Self-Reflection

The significant amount of time spent on researching and pondering the possible interventions felt worth it when presenting the information and conducting the simulation. The researchers felt confident in their knowledge of the material and the way in which it was presented. The PowerPoint presentation provided a good foundation about rural homelessness and the role both narrative therapy and trauma-informed care plays in treatment. Although the researches had technical difficulties displaying the curriculum for the class, their solid knowledge of the material allowed them to effectively explain the therapy process, despite the difficulty. Regarding the simulation, the flow of the session felt natural and intentional. There were a few questions and phrases that could have been stated in a way that better empowered the client. The definitional ceremony went better than expected and ended up feeling very

realistic. The closing of the session felt slightly rushed. Additional time to debrief the ceremony and talk through the termination process more in depth would have been helpful. All in all, the researchers were pleased with how the presentation and simulation were carried out.

Evaluation

This curriculum uses evidence-based interventions that have been effective for the population, or for the specific issues encountered by the population. The structure of the curriculum allows for a variety of interventions in each session, all aimed to intentionally meet a goal of the curriculum as a whole. Each week includes the goals and objectives of that particular session as well as a purpose statement, allowing the therapist to have a clear idea of what is driving the session. There is also a checklist of the materials needed to perform the interventions in said session, which will allow the therapist to be well prepared.

Each session has the same rhythm, including a breathe-in section, an education section, an intervention section, and a breathe-out section. This repeated rhythm allows the client to gain comfortability, knowing what to anticipate coming into session. The breathe-in section is designed to mentally and emotionally prepare the client, encouraging a relaxed, open state of mind. Each week consists of a different mindfulness activity, designed to center the client and assist in decreasing stress. The breathe-in section is valuable for the client to learn a variety of techniques for lowering stress levels.

The final breathe-in section is a powerful activity that allows the clients to speak positive affirmations over themselves. When the researches performed this intervention in a mock session, it was found that some improvements were needed. The researchers performed this intervention by speaking each affirmation out loud and then having the clients repeat them. The affirmation phrases used were too long in length and included big words, causing the clients to

forget what had been said. Alterations will need to be made to this activity in order for it to be appropriate for the clients' age and intellect.

The education section allows the client to be informed on narrative therapy and other interventions used in session. In narrative therapy, the client is equipped to become the expert of their story, and psychoeducation provides them the resources needed. Although educating the client on narrative therapy is necessary, there are a variety of ways that this could be done and it can be altered as the therapist sees appropriate for themselves and the client. The curriculum also includes education for parents that the researchers believed to be helpful for the specific population. It should be noted that every family is different and the parenting education might need alteration to suit different family dynamics. Even if altered, the educational section of this curriculum is valuable in allowing the client to feel informed and to have a better understanding of where they are and where they are trying to go.

The activity and intervention section includes a variety of different activities which take the client on a journey of discovering their narrative and rewriting it in a more empowering way. Because these activities build off of one another, it is important that the therapist is attentive to how the client interprets the activity. The curriculum is set in a hypothetical situation, where everything goes smoothly. However, it might not go smoothly in real life. If the client does not connect with an activity or understand a concept, it might be necessary to come back to it and expand the number of sessions for the curriculum. All activities used in this curriculum are either evidence-based or use evidence-based concepts.

In the final session, the activity is a definitional ceremony. This intervention allows the clients to solidify their new narratives among the witness of important people in their lives. Although this intervention was found to be successful when used in a mock therapy session,

some flaws and possible negative outcomes were found. If a therapist is planning to do a definitional ceremony at the final session, it is important that they pay close attention to the clients' support system throughout therapy. Being aware of the support system allows the therapist to make an educated decision on whether or not a definitional ceremony with guests is appropriate. The therapist would want to avoid asking the client to invite guests in the instance that there is no one able or willing to attend. In this scenario, the client would be at a major risk for discouragement and doubt in the progress made. Guests should also be provided with questions and information ahead of time to aid in the effectiveness of the ceremony.

The breathe-out section of the curriculum gives the client tasks to complete in between sessions. This section is valuable in allowing the clients to continue to grow and get a grasp on the concepts, while also providing opportunities to apply what they are learning in session to lives outside of session. With the homeless population, it is especially important for the therapist to take note of what the clients' situation is when they leave. It is important for the client to have the resources necessary to perform tasks outside of sessions, and activities may need to be altered in order to accommodate different clients and their situations.

Improvement of Practice

The researchers found two major flaws in the mock session that was performed using this curriculum and its interventions. The first of these flaws was in the affirmations activity and the second was in the definitional ceremony. While these flaws were not detrimental to the session, the researchers, through experience and feedback, were able to see the potential dangers of these flaws.

It was noted that the affirmations activity needs to accommodate the age and intellect of the clients, which could be carried out in a variety of ways. One way to solve the issue seen in

session is by modifying the affirmations that are repeated. Using shorter sentences and simpler words would allow the client to feel confident and competent verbalizing the affirmations. It could be more effective to ask the client write their own affirmations, instead of the therapist creating generic affirmations. This activity could also be modified by printing out the list of affirmations and giving the list to the clients for reference. The potential issue with allowing the clients to use a script would be the inability to connect with eye contact as the affirmations are spoken.

In the definitional ceremony, the guests were not aware of exactly what was happening and what their participation involved. The actors in the mock session were unsure of their role and afraid of providing insufficient answers to the therapist's questions. The uncertainty of the ceremony guests could cause harmful doubt for the clients and their progress. In order to counteract this potential result, the therapist should be in communication with the guests before the ceremony, clearly defining the guest role and preparing them to support the client. Assisting the guests in being aware beforehand does not undermine their voice but rather, it allows preparation for people that struggle being put on the spot.

Significance

The most significant part of this project has been visibly seeing how theory on paper becomes practice in real life. There is so much more intentional thinking that goes into family therapy than one might think. The project provided a greater appreciation for all therapy providers as it is no easy task. It has been influential seeing how theories really are designed to help people, down to the very small, often missed details. The researchers have learned that no script can prepare a therapist for human interaction. Things will be said that couldn't have been predicted. Emotions will arise that couldn't have been prepared for. The most essential piece of

family therapy is the raw and real human interaction and connecting with the human sitting in the room. Whether using narrative therapy, CBT, or structural family therapy, therapists must acknowledge that it is the client who holds the power to change and overcome. The therapist's job, as narrative therapy describes, is to co-author in the story being created.

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Appendix

Figure 1

Trauma assessment for adult

Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

Youth Self-Report

DATE _____ NAME _____ RECORD ID _____

AGE _____ SEX ☐ Male ☐ Female

RACE ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other (Specify): _____

ETHNICITY ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

PART 1 TRAUMA-RELATED EXPERIENCES

INSTRUCTIONS We are going to go through a list of very scary things that sometimes happen to people. Choose YES if the thing happened to you or NO if it has not happened to you. For each 'YES' response, write your age when the scary or bad thing happened or started happening on the line next to the 'YES.'

1. Have you ever been in a really bad storm or disaster, like a flood, earthquake, or hurricane? ☐ NO ☐ YES About how old were you? _____
2. Have you or anyone in your family been in an actual war? ☐ NO ☐ YES About how old were you? _____
3. Have you ever been in a serious fire or lost your home in a fire? ☐ NO ☐ YES About how old were you? _____
4. Have you ever been in a really bad car accident? ☐ NO ☐ YES About how old were you? _____
5. Have you ever had to stay in the hospital because you were really sick or badly injured? ☐ NO ☐ YES About how old were you? _____
6. Has anyone in your family ever had to stay in the hospital because they were really sick or badly injured? ☐ NO ☐ YES About how old were you? _____
7. Has anyone ever beaten you up so badly that you had bruises, cuts, or injuries? ☐ NO ☐ YES About how old were you? _____
8. Have adults in your home ever slapped, punched, or kicked you? ☐ NO ☐ YES About how old were you? _____
9. Have adults in your home ever hit you so hard you had bruises or red marks? ☐ NO ☐ YES About how old were you? _____
10. Have you ever been really hungry because your family did not have enough to eat? ☐ NO ☐ YES About how old were you? _____
11. Did the adults in your home not care if you regularly went to school? ☐ NO ☐ YES About how old were you? _____
12. Have you ever been homeless? ☐ NO ☐ YES About how old were you? _____
13. Have you ever been separated from someone you depend on for love or safety for more than a few days? ☐ NO ☐ YES About how old were you? _____
14. Have you ever known or seen a family member being arrested, put in jail, or taken away by police? ☐ NO ☐ YES About how old were you? _____

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Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 1)

15. Have you ever been told over and over that you were no good or that people you live with would leave you or send you away? ☐ NO ☐ YES About how old were you? _____
16. Have you ever seen or heard adults in your home beat each other up or throw things at each other? ☐ NO ☐ YES About how old were you? _____
17. Have you ever seen or heard people in your neighborhood get badly hurt or killed? ☐ NO ☐ YES About how old were you? _____
18. Has anyone ever told you so much about how someone you loved died that you pictured it in your head? ☐ NO ☐ YES About how old were you? _____
19. Has anyone ever told you they were going to hurt or kill you? ☐ NO ☐ YES About how old were you? _____
20. Has anyone ever made you feel so scared that you thought they might badly hurt or kill you? ☐ NO ☐ YES About how old were you? _____
21. Have you ever thought that someone was going to really hurt or kill someone you love? ☐ NO ☐ YES About how old were you? _____
22. Has anyone ever tried to touch your private body parts or tried to make you touch their private body parts when you did not want to? ☐ NO ☐ YES About how old were you? _____
23. Has anyone ever touched your private body parts or made you touch their private body parts when you did not want to? ☐ NO ☐ YES About how old were you? _____
24. Has anyone much older than you ever touched your private body parts, whether you wanted them to or not? ☐ NO ☐ YES About how old were you? _____
25. Has anything else really scary or very bad ever happened to you? *Specify* [☐ NO ☐ YES About how old were you? _____

If you said YES to any of the above questions, continue to PART 2 below

PART 2 SYMPTOMS & IMPAIRMENT

These questions ask about problems some people have after scary or bad things happen to them. Please think about a scary or bad thing that happened to you and how you have been thinking, feeling, or acting in the PAST WEEK when answering these questions. Check your answer.

26. How often did thoughts or memories about what happened pop up into your mind? ☐ NONE ☐ 1 DAY ☐ 2-3 DAYS ☐ MOST DAYS
27. When something reminded you about what happened, how often did it make your body feel bad or sick, like your stomach or head hurt? ☐ NONE ☐ 1 DAY ☐ 2-3 DAYS ☐ MOST DAYS

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Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 3)

45. In the past week, how often did you wake up in the middle of the night and have trouble falling back to sleep? ☐ NONE ☐ 1 DAY ☐ 2-3 DAYS ☐ MOST DAYS
46. How often was it hard for you to feel happiness or love? ☐ NONE ☐ 1 DAY ☐ 2-3 DAYS ☐ MOST DAYS
47. How often did it feel like you didn't know yourself or your own body, like you were seeing a stranger when you looked in the mirror? ☐ NONE ☐ 1 DAY ☐ 2-3 DAYS ☐ MOST DAYS
48. How often did you feel like people or places around you seemed totally strange, like you were in a dream even though you were awake? ☐ NONE ☐ 1 DAY ☐ 2-3 DAYS ☐ MOST DAYS
49. Have you had these problems for at least the past month? ☐ NO ☐ YES

Since the scary or bad thing or things happened is it harder to…

50. Make or keep friends ☐ NO ☐ YES
51. Get along with other kids your age ☐ NO ☐ YES
52. Do schoolwork ☐ NO ☐ YES
53. Get along with your teachers ☐ NO ☐ YES
54. Get along with people you live with ☐ NO ☐ YES
55. Get your chores done ☐ NO ☐ YES

YOU ARE FINISHED

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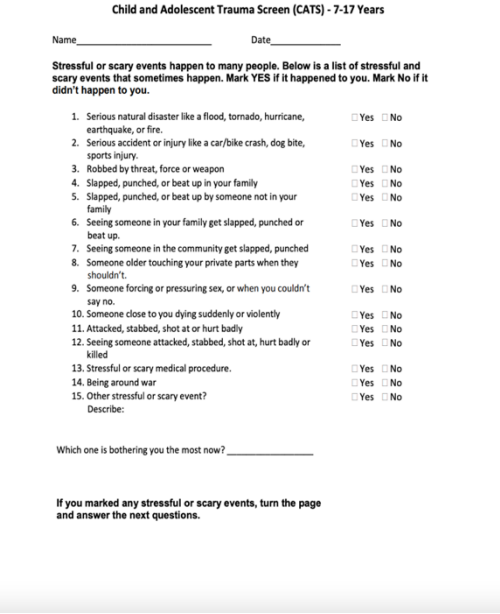
Structured Trauma-Related Experiences and Symptoms Screener (STRESS)

(Continued from Page 2)

28. In the past week, how often was it hard to remember parts of what happened?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
29. How often were you bored doing things you usually like to do?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
30. In the past week, how often did you look around a lot, just in case something bad might happen?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
31. How often did you have scary dreams or nightmares?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
32. How often did you try to keep your body from feeling ways that reminded you of what happened?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
33. How often did you think the world is a bad place or not as good as it used to be?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
34. In the past week, how often did you feel lonely, even when you were around friends or family?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
35. How often did you get really scared when you heard or saw something you were not expecting to happen?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
36. How often did memories about what happened make you lose track of time or forget where you were?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
37. How often did you try to stop yourself from having thoughts, memories, or feelings about what happened?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
38. In the past week, how often did you think that a part of what happened was your fault?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
39. How often did you feel really grumpy?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
40. How often did you feel like you could not focus on things?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
41. How often did you get really upset when you saw, heard, or felt something like what happened?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
42. How often did you try to get away when you were in a place or saw something that reminded you of what happened?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
43. How often did you feel really bad, like mad, scared, or sad for most of the day?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS
44. How often did you do things that other people think are dangerous or not safe?	☐ NONE	☐ 1 DAY	☐ 2-3 DAYS	☐ MOST DAYS

Figure 2

Trauma assessment for child



Child and Adolescent Trauma Screen (CATS) - 7-17 Years

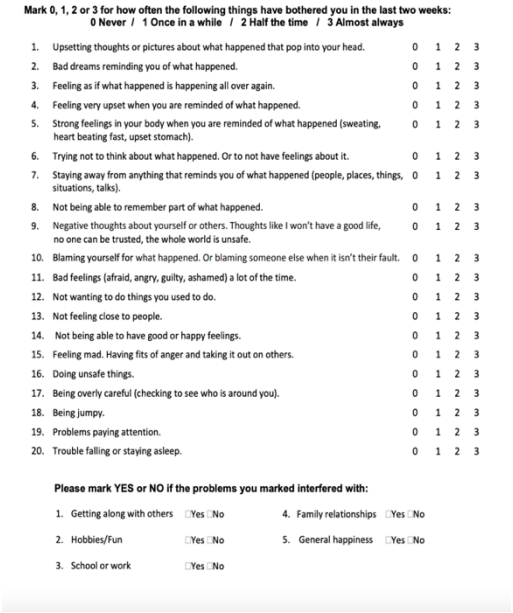
Name_____ Date_____

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire. ☐ Yes ☐ No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury. ☐ Yes ☐ No
3. Robbed by threat, force or weapon ☐ Yes ☐ No
4. Slapped, punched, or beat up in your family ☐ Yes ☐ No
5. Slapped, punched, or beat up by someone not in your family ☐ Yes ☐ No
6. Seeing someone in your family get slapped, punched or beat up. ☐ Yes ☐ No
7. Seeing someone in the community get slapped, punched ☐ Yes ☐ No
8. Someone older touching your private parts when they shouldn't. ☐ Yes ☐ No
9. Someone forcing or pressuring sex, or when you couldn't say no. ☐ Yes ☐ No
10. Someone close to you dying suddenly or violently ☐ Yes ☐ No
11. Attacked, stabbed, shot at or hurt badly ☐ Yes ☐ No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed ☐ Yes ☐ No
13. Stressful or scary medical procedure. ☐ Yes ☐ No
14. Being around war ☐ Yes ☐ No
15. Other stressful or scary event? Describe: ☐ Yes ☐ No

Which one is bothering you the most now? _____

If you marked any stressful or scary events, turn the page and answer the next questions.



Mark 0, 1, 2 or 3 for how often the following things have bothered you in the last two weeks:
0 Never / 1 Once in a while / 2 Half the time / 3 Almost always

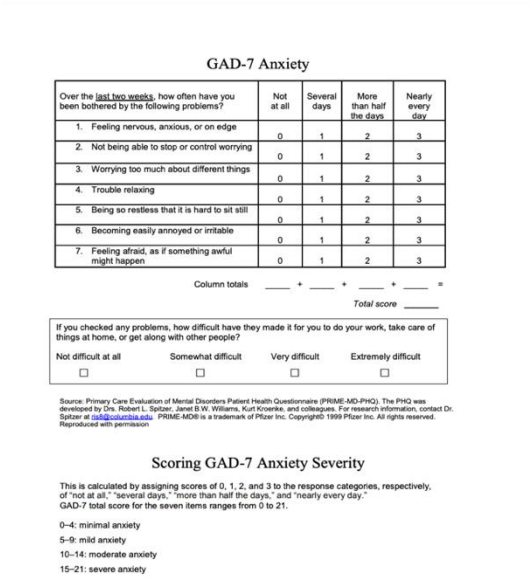
1.	Upsetting thoughts or pictures about what happened that pop into your head.	0	1	2	3
2.	Bad dreams reminding you of what happened.	0	1	2	3
3.	Feeling as if what happened is happening all over again.	0	1	2	3
4.	Feeling very upset when you are reminded of what happened.	0	1	2	3
5.	Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach).	0	1	2	3
6.	Trying not to think about what happened. Or to not have feelings about it.	0	1	2	3
7.	Staying away from anything that reminds you of what happened (people, places, things, situations, talks).	0	1	2	3
8.	Not being able to remember part of what happened.	0	1	2	3
9.	Negative thoughts about yourself or others. Thoughts like I won't have a good life, no one can be trusted, the whole world is unsafe.	0	1	2	3
10.	Blaming yourself for what happened. Or blaming someone else when it isn't their fault.	0	1	2	3
11.	Bad feelings (afraid, angry, guilty, ashamed) a lot of the time.	0	1	2	3
12.	Not wanting to do things you used to do.	0	1	2	3
13.	Not feeling close to people.	0	1	2	3
14.	Not being able to have good or happy feelings.	0	1	2	3
15.	Feeling mad. Having fits of anger and taking it out on others.	0	1	2	3
16.	Doing unsafe things.	0	1	2	3
17.	Being overly careful (checking to see who is around you).	0	1	2	3
18.	Being jumpy.	0	1	2	3
19.	Problems paying attention.	0	1	2	3
20.	Trouble falling or staying asleep.	0	1	2	3

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others ☐Yes ☐No
2. Hobbies/Fun ☐Yes ☐No
3. School or work ☐Yes ☐No
4. Family relationships ☐Yes ☐No
5. General happiness ☐Yes ☐No

Figure 3

Anxiety assessment for adult



GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals ____ + ____ + ____ + ____ =

Total score ____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

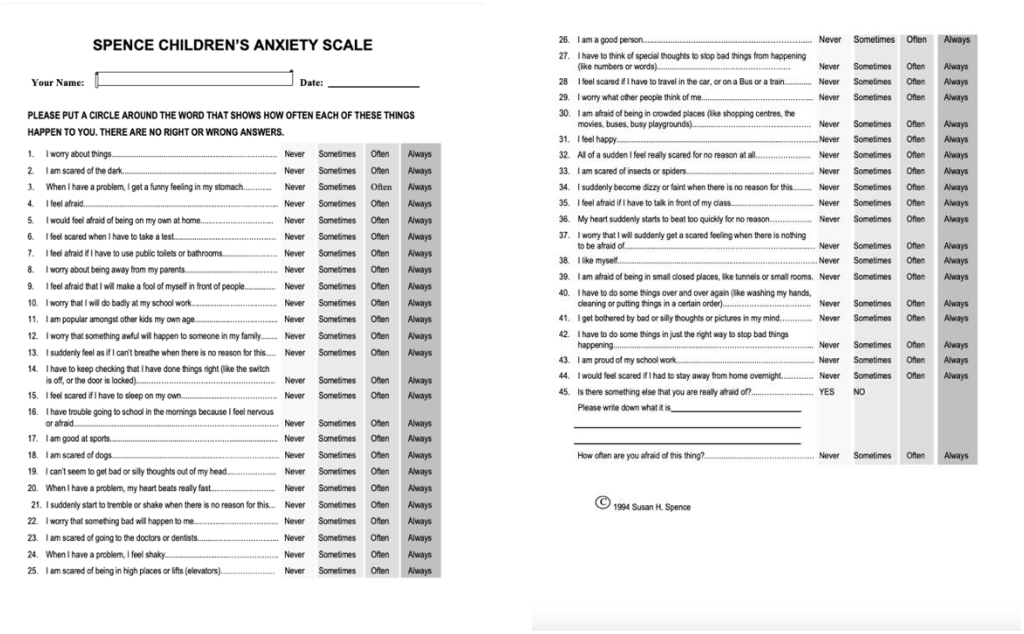
Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety
5–9: mild anxiety
10–14: moderate anxiety
15–21: severe anxiety

Figure 4

Anxiety assessment for child



SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____ Date: _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1. I worry about things	Never	Sometimes	Often	Always
2. I am scared of the dark	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4. I feel afraid	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6. I feel scared when I have to take a test	Never	Sometimes	Often	Always
7. I feel afraid if I have to use public toilets or bathrooms	Never	Sometimes	Often	Always
8. I worry about being away from my parents	Never	Sometimes	Often	Always
9. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
10. I worry that I will do badly at my school work	Never	Sometimes	Often	Always
11. I am popular amongst other kids my own age	Never	Sometimes	Often	Always
12. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
13. I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
14. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
15. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
16. I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
17. I am good at sports	Never	Sometimes	Often	Always
18. I am scared of dogs	Never	Sometimes	Often	Always
19. I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
20. When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
21. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
22. I worry that something bad will happen to me	Never	Sometimes	Often	Always
23. I am scared of going to the doctors or dentists	Never	Sometimes	Often	Always
24. When I have a problem, I feel shaky	Never	Sometimes	Often	Always
25. I am scared of being in high places or lifts (elevators)	Never	Sometimes	Often	Always
26. I am a good person	Never	Sometimes	Often	Always
27. I have to think of special thoughts to stop bad things from happening (like numbers or words)	Never	Sometimes	Often	Always
28 I feel scared if I have to travel in the car, or on a Bus or a train	Never	Sometimes	Often	Always
29. I worry what other people think of me	Never	Sometimes	Often	Always
30. I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
31. I feel happy	Never	Sometimes	Often	Always
32. All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
33. I am scared of insects or spiders	Never	Sometimes	Often	Always
34. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
35. I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
36. My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
37. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
38. I like myself	Never	Sometimes	Often	Always
39. I am afraid of being in small closed places, like tunnels or small rooms.	Never	Sometimes	Often	Always
40. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
41. I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
42. I have to do some things in just the right way to stop bad things happening	Never	Sometimes	Often	Always
43. I am proud of my school work	Never	Sometimes	Often	Always
44. I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
45. Is there something else that you are really afraid of?	YES	NO		
Please write down what it is _____				
How often are you afraid of this thing?	Never	Sometimes	Often	Always

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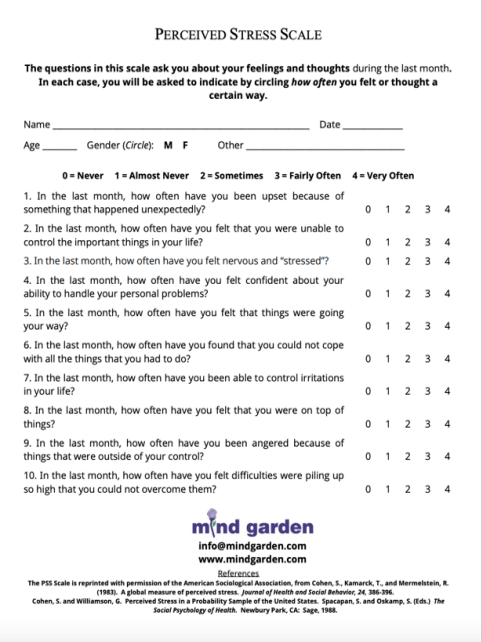
Figure 5

Stress assessment for adult



PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month. **In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.**

Name _____ Date _____

Age _____ Gender (*Circle*): **M F** Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly? 0 1 2 3 4
2. In the last month, how often have you felt that you were unable to control the important things in your life? 0 1 2 3 4
3. In the last month, how often have you felt nervous and "stressed"? 0 1 2 3 4
4. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4
5. In the last month, how often have you felt that things were going your way? 0 1 2 3 4
6. In the last month, how often have you found that you could not cope with all the things that you had to do? 0 1 2 3 4
7. In the last month, how often have you been able to control irritations in your life? 0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things? 0 1 2 3 4
9. In the last month, how often have you been angered because of things that were outside of your control? 0 1 2 3 4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? 0 1 2 3 4

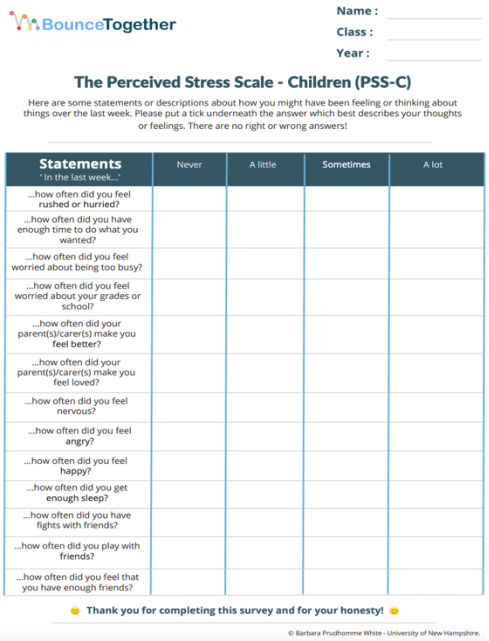
mind garden
info@mindgarden.com
www.mindgarden.com

References

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*, 386-396.
Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.) *The Social Psychology of Health*. Newbury Park, CA: Sage, 1988.

Figure 6

Stress assessment for child



BounceTogether

Name :
Class :
Year :

The Perceived Stress Scale - Children (PSS-C)

Here are some statements or descriptions about how you might have been feeling or thinking about things over the last week. Please put a tick underneath the answer which best describes your thoughts or feelings. There are no right or wrong answers!

Statements ' In the last week...'	Never	A little	Sometimes	A lot
...how often did you feel rushed or hurried?				
...how often did you have enough time to do what you wanted?				
...how often did you feel worried about being too busy?				
...how often did you feel worried about your grades or school?				
...how often did your parent(s)/carer(s) make you feel better?				
...how often did your parent(s)/carer(s) make you feel loved?				
...how often did you feel nervous?				
...how often did you feel angry?				
...how often did you feel happy?				
...how often did you get enough sleep?				
...how often did you have fights with friends?				
...how often did you play with friends?				
...how often did you feel that you have enough friends?				

Thank you for completing this survey and for your honesty!

Figure 7

Psychoeducation for narrative therapy

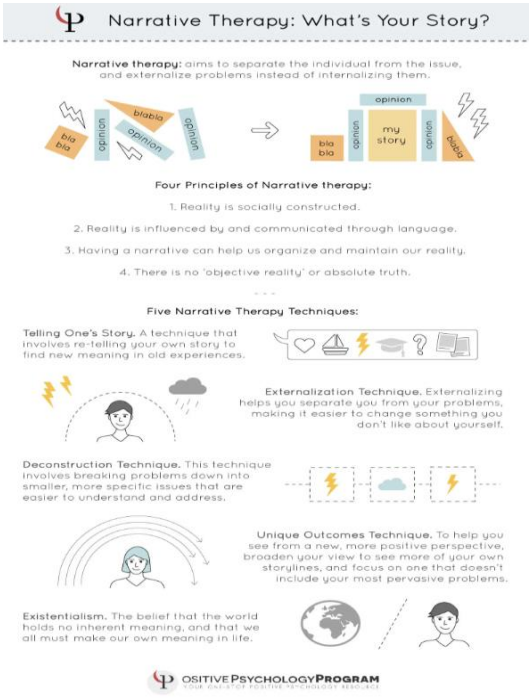
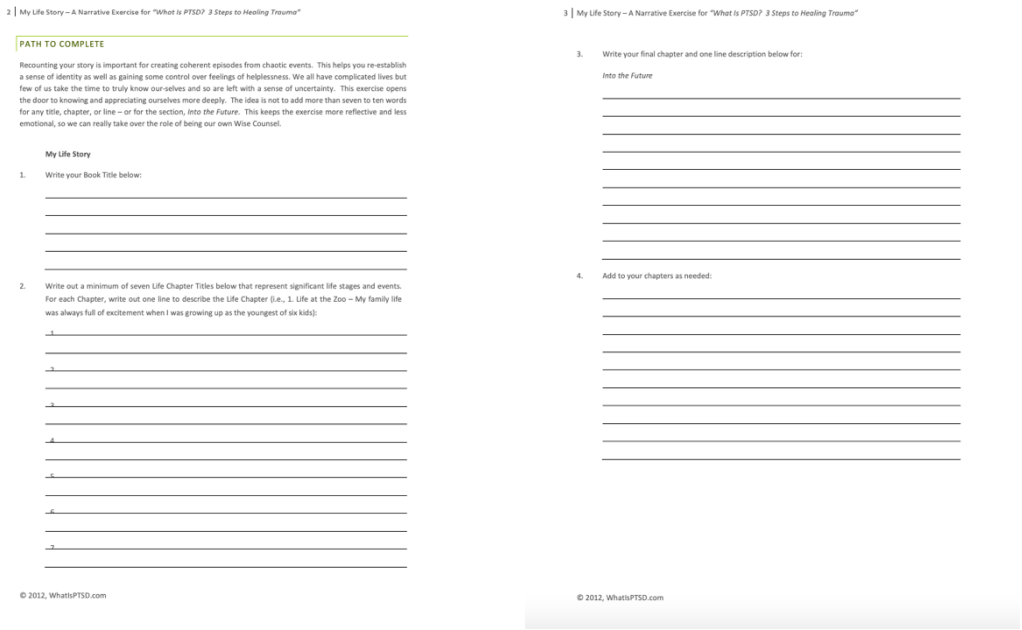


Figure 8

My Life Story Worksheet


2 | My Life Story – A Narrative Exercise for *"What Is PTSD? 3 Steps to Healing Trauma"*

PATH TO COMPLETE

Recounting your story is important for creating coherent episodes from chaotic events. This helps you re-establish a sense of identity as well as gaining some control over feelings of helplessness. We all have complicated lives but few of us take the time to truly know our-selves and so are left with a sense of uncertainty. This exercise opens the door to knowing and appreciating ourselves more deeply. The idea is not to add more than seven to ten words for any title, chapter, or line – or for the section, *Into the Future*. This keeps the exercise more reflective and less emotional, so we can really take over the role of being our own Wise Counsel.

My Life Story

1. Write your Book Title below:

2. Write out a minimum of seven Life Chapter Titles below that represent significant life stages and events. For each Chapter, write out one line to describe the Life Chapter (i.e., 1. Life at the Zoo – My family life was always full of excitement when I was growing up as the youngest of six kids):

1.
2.
3.
4.
5.
6.
7.

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3 | My Life Story – A Narrative Exercise for *"What Is PTSD? 3 Steps to Healing Trauma"*

3. Write your final chapter and one line description below for:

Into the Future

4. Add to your chapters as needed:

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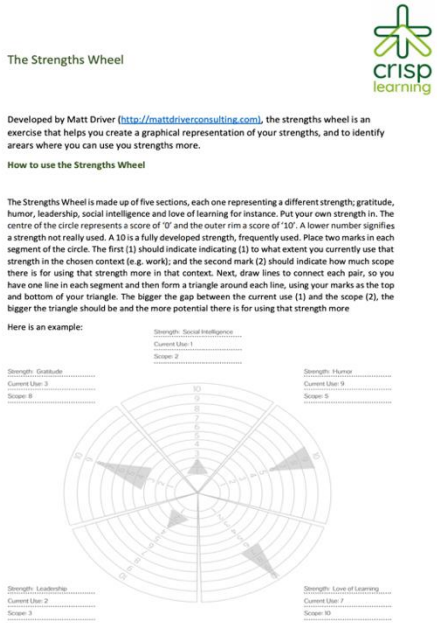
Figure 9

Strengths wheel



The Strengths Wheel

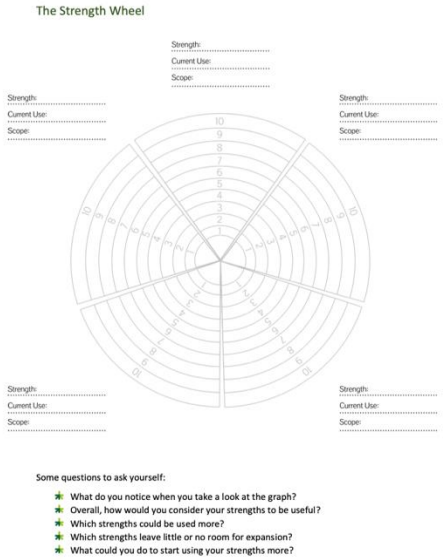
crisp learning

Developed by Matt Driver (http://mattdriverconsulting.com), the strengths wheel is an exercise that helps you create a graphical representation of your strengths, and to identify arears where you can use you strengths more.

How to use the Strengths Wheel

The Strengths Wheel is made up of five sections, each one representing a different strength; gratitude, humor, leadership, social intelligence and love of learning for instance. Put your own strength in. The centre of the circle represents a score of '0' and the outer rim a score of '10'. A lower number signifies a strength not really used. A 10 is a fully developed strength, frequently used. Place two marks in each segment of the circle. The first (1) should indicate indicating (1) to what extent you currently use that strength in the chosen context (e.g. work); and the second mark (2) should indicate how much scope there is for using that strength more in that context. Next, draw lines to connect each pair, so you have one line in each segment and then form a triangle around each line, using your marks as the top and bottom of your triangle. The bigger the gap between the current use (1) and the scope (2), the bigger the triangle should be and the more potential there is for using that strength more

Here is an example:



The Strength Wheel

Strength:
Current Use:
Scope:

Some questions to ask yourself:

- What do you notice when you take a look at the graph?
- Overall, how would you consider your strengths to be useful?
- Which strengths could be used more?
- Which strengths leave little or no room for expansion?
- What could you do to start using your strengths more?

Figure 10

Guided Imagery for therapist

Soaring above pain

Dorset HealthCare NHS
University NHS Foundation Trust
Dorset Community Pain Service

Guided Imagery: Safe Place

Allow yourself to be in a comfortable position, either lying down or sitting up. If you're sitting up, place a pillow behind your back, and allow your neck and your back to be nicely supported, not leaning back too much if you have difficulty staying awake.

Remember that if you feel afraid at any time, just open your eyes and ground yourself in today. You are safe and you are in control today.

How does it feel? Let your body begin to relax by releasing the areas of tension by breathing. Take slow deep breaths and as you exhale let the tension go. Where is your body feeling tense? Focus your attention on this area as you take another breath in. Feel this area relaxing as you breathe out. Allow your breathing to gradually slow down.

Breathe in and out

As you do this, allow yourself to picture in your mind's eye, a safe place. What is the first place that comes to mind? What type of place does your mind choose as a safe place? In this place of safety, no one can come without your invitation. In this place of safety, you are always at peace.

Maybe you are in a beautiful garden, or in the mountains, or in an open field or the beach. Picture a place that feels calm, safe, and serene. A place you feel safe and protected. Each time you come to your safe place, you may develop it and allow it to become more and more beautiful. Allow yourself to see what is here today

Imagine the details of your surroundings. Notice the foliage and beautiful colours and hues. What season is it? Notice the ground. Is it earthy soil, rock, or sand? Are you barefooted? What does it feel like beneath your feet?

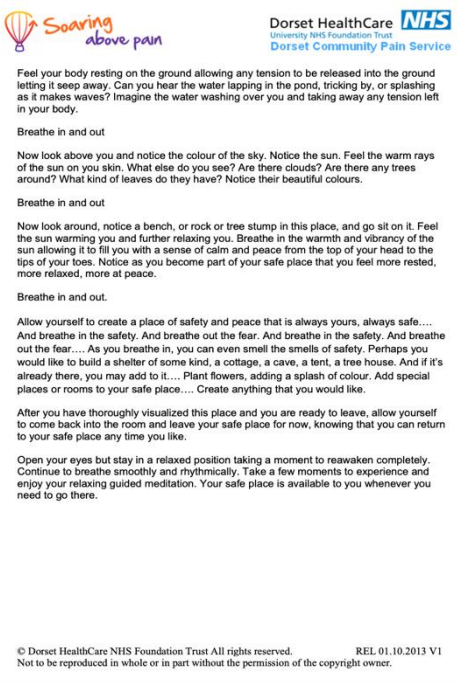
What smells do you notice? Is it sweet, pungent, or refreshing? Are there birds overhead? Listen to their singing. What other sounds do you hear? Let these sounds lull you peacefully.

Notice if there is any water. Is there a pond or a waterfall or waves? Can you hear the sound of the water? Let the water flow over your skin. Notice how it feels on your skin. Can you taste it?

Notice if there is a breeze or wind. What does it feel like on your face? Is it warm or cool? Allow yourself to take in all the senses feeling calm, serene, and peaceful.

Breathe in and out

Now allow yourself to lie down in the safe place and feel the ground beneath your body. Notice
the gentle earth below warming you. Imagine the earth cradling you allowing you to relax even more and feel safe during this meditation.



Soaring above pain

Dorset HealthCare NHS
University NHS Foundation Trust
Dorset Community Pain Service

Feel your body resting on the ground allowing any tension to be released into the ground letting it seep away. Can you hear the water lapping in the pond, tricking by, or splashing as it makes waves? Imagine the water washing over you and taking away any tension left in your body.

Breathe in and out

Now look above you and notice the colour of the sky. Notice the sun. Feel the warm rays of the sun on you skin. What else do you see? Are there clouds? Are there any trees around? What kind of leaves do they have? Notice their beautiful colours.

Breathe in and out

Now look around, notice a bench, or rock or tree stump in this place, and go sit on it. Feel the sun warming you and further relaxing you. Breathe in the warmth and vibrancy of the sun allowing it to fill you with a sense of calm and peace from the top of your head to the tips of your toes. Notice as you become part of your safe place that you feel more rested, more relaxed, more at peace.

Breathe in and out.

Allow yourself to create a place of safety and peace that is always yours, always safe…. And breathe in the safety. And breathe out the fear. And breathe in the safety. And breathe out the fear…. As you breathe in, you can even smell the smells of safety. Perhaps you would like to build a shelter of some kind, a cottage, a cave, a tent, a tree house. And if it's already there, you may add to it…. Plant flowers, adding a splash of colour. Add special places or rooms to your safe place…. Create anything that you would like.

After you have thoroughly visualized this place and you are ready to leave, allow yourself to come back into the room and leave your safe place for now, knowing that you can return to your safe place any time you like.

Open your eyes but stay in a relaxed position taking a moment to reawaken completely. Continue to breathe smoothly and rhythmically. Take a few moments to experience and enjoy your relaxing guided meditation. Your safe place is available to you whenever you need to go there.