Published in final edited form as:

J Trauma Stress. 2010 December ; 23(6): 802–806. doi:10.1002/jts.20587.

Strengthening Family Coping Resources: The Feasibility of a Multifamily Group Intervention for Families Exposed to Trauma*

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Abstract

Families exposed to urban poverty face a disproportionate risk of exposure to repeated trauma. Repeated exposures can lead to severe and chronic reactions in multiple family members with effects that ripple throughout the family system. Interventions for distressed families residing in traumatic contexts, such as low-income, urban settings are desperately needed. This report presents preliminary data in support of Strengthening Family Coping Resources, a trauma-focused, multifamily, skill-building intervention. Strengthening Family Coping Resources is designed for families living in traumatic contexts with the goal of reducing symptoms of posttraumatic stress disorder and other trauma-related disorders in children and caregivers. Results from open trials suggest Strengthening Family Coping Resources is a feasible intervention with positive effects on children's symptoms of trauma-related distress.

Families residing in urban communities are besieged by stressful events and often exposed to severe and chronic traumas, including family violence, drug activity, incarceration of family members, and personal victimization in the school and community. Consistent with a family systems framework, there is strong empirical evidence that living under chronically harsh, traumatic circumstances negatively impacts individual family members, multiple family subsystems, and slowly erodes family unit processes including family structure, relations, and coping (Howes, Cicchetti, Toth, & Rogosch, 2000; Kiser & Black, 2005).

*This article was edited by the journal's Editor-Elect, Daniel S. Weiss.

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Several studies have explored the relationships among trauma exposure, childhood traumatic stress, and family functioning (Banyard, Rozelle, & Englund, 2001; Pinderhughes, Nix, Foster, & Jones, 2001) including a cross-sectional study conducted by Kiser, Medoff, and Black (2010) of 100 parent-child dyads residing in low-income urban communities. For children whose parents or caregivers placed less value on family routines, reexperiencing and avoidance symptoms were significantly increased. Higher ratings of family structure predicted fewer internalizing and externalizing behavior problems. To further explore the effects of chronic trauma on family life, structured interviews were conducted with a subsample of 16 caregivers whose children displayed symptoms of posttraumatic stress disorder (PTSD). Caregivers often expressed frustration with their parenting role due to the daily hassles and stressors associated with living in urban poverty, which were compounded by the extra demands of taking care of a child with trauma-related symptoms. However, several families also described employing various coping strategies to increase organization, stabilize family routines, and to help them process their traumatic experiences (Kiser, Nurse, Luckstead, & Collins, 2008).

Trauma treatment is traditionally delivered to individuals. Evidence suggests that cognitive behavioral therapy (CBT) approaches with children and adults are more effective than no treatment or nontrauma specific treatment (e.g., Cohen, Mannarino, & Knudsen, 2005). Despite CBT's efficacy, there are questions as to its applicability for treating families living under chronically harsh, traumatic circumstances. Currently available trauma-specific CBT models primarily focus on management of PTSD symptoms and do not address the systemic effects of traumatic distress on families.

Empirically supported interventions for families living in traumatic contexts are limited; however, family behavioral and skill-building interventions for distressed families have strong empirical support. Several studies demonstrate increases in positive parenting practices, significant improvements in parental self-efficacy, and lower distress following participation in such interventions (Dishion & Andrews, 1995; Taylor & Biglan, 1998). Multifamily groups have shown to be effective in addressing the needs of families living in stressful settings, and are associated with higher rates of service use, reductions in child behavior problems, and improvements in family functioning (Snell-Johns, Mendez, & Smith, 2004).

Given the impact of trauma on all family members and the mismatch with individual treatment strategies, the development of an intervention for families living in traumatic contexts was warranted. In developing a new family-based trauma treatment approach, we followed the multistep process outlined by the National Institute on Drug Abuse's (NIDA) stage model of behavioral therapies research (Rousaville, Carroll, & Onken, 1999). Here we report findings from open trials on Strengthening Family Coping Resources (Kiser, 2006) completing phase II of this process.

METHOD

Participants

The sample included children, ages 1 through 12 years, recruited from urban outpatient clinics. Families were eligible for the intervention if one of their children had been exposed to multiple traumas that met Criterion A according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV TR*; American Psychiatric Association, 2000) and also met partial or full criteria for PTSD on the Schedule for Affective Disorders and Schizophrenia for School Age Children-Present (K-SADS P/L). For children unable to complete the K-SADS P/L, either due to age or logistical constraints at one of the participating sites, an alternate measure of PTSD symptoms was completed. For children

under 6 years of age, the Trauma Symptom Checklist for Young Children (Briere et al., 2001) was used, and for children 6 and older, the UCLA PTSD Index (Steinberg, Brymer, Decker, & Pynoos, 2004) was used.

Children were excluded only if they had active suicide ideation, active psychosis, severe mental retardation, brain injury, or an imminent risk for reexposure due to their living environment (e.g., ongoing violence at home). Although the need for treatment is high for children in dangerous living situations, the primary concern was to establish a safe, stable environment, at which point they could then enroll in the group. Additionally, children were required to be in the custody of a stable caregiver who did not have active psychosis and was not a danger to him- or herself or others.

Forty-five families participated in the initial screening assessment. Of those families, 36 attended at least one group session and 19 families completed Strengthening Family Coping Resources (defined as attending the final graduation session). Pre- and post-data from 19 children were available.

Measures

The Child Behavior Checklist (Achenbach & Edelbrock, 1991) requires a parent to rate, on a 3-point scale, each of 118 problems as they are perceived to reflect the child's behavior over the past 2 months. The instrument measures 8–9 subscales that can be collapsed into internalizing, externalizing, and total problems scores. Statistical data on reliability and validity have been well established (Achenbach & Edelbrock, 1991).

The Schedule for Affective Disorders and Schizophrenia for School Age Children–Present (Kaufman, Birmaher, Brent, Rao, & Ryan, 1995) are semistructured diagnostic interviews keyed to *DSM-IV* for children between the ages of 6–18 years. Interrater agreement ranges between 93–100% and test-retest reliabilities for current diagnosis of PTSD range between .56–.67 (Kaufman, Birmaher, Brent, Rao, & Ryan, 1997).

Procedure

The study used a pre- and postdesign to allow for close monitoring of the intervention structure and content. The outcomes of interest were the process measures collected to monitor participation in the group interventions, clinician competence, intervention integrity, and child outcomes. In the current pilot study, one child from each family was identified and evaluated. The target child and his or her primary caregiver completed the assessment battery in individual sessions prior to enrolling in the group and after completion of the intervention. If there were multiple children in the family who were exposed to trauma, the child who was exhibiting the most trauma-related distress was chosen for the evaluation. Although all family members participated in the group, for this pilot research only one child participated in the assessment process.

Using a behavioral, skill-building, multifamily group framework, Strengthening Family Coping Resources teaches constructive coping resources to strengthen a family's protective function that is potentially vulnerable to chronic exposure to chronic stress and trauma. Strengthening Family Coping Resources is a manualized, trauma-specific intervention that addresses the physiological, cognitive, behavioral, affective, and social mechanisms that influence the critical symptoms of trauma-related disorder using empirically supported treatment components, including cognitive therapy, anxiety management training, supportive therapy, and exposure therapy. By delivering treatment components in a manner that successfully engages all family members in the healing process, the pathology that often coexists in multiple family members can be addressed simultaneously. Strengthening Family Coping Resources links these trauma treatment components with family-level, coping skill

development addressing the systemic impact of trauma and the ecological impact of urban poverty. Drawing on coping theory, family ritual and routine theory, attachment theory, and social support theory, Strengthening Family Coping Resources fosters the following protective family coping resources: deliberateness, structure and a sense of safety, connectedness, resource seeking, coregulation and crisis management, and positive affect, memories, and meaning. Each of these treatment components has been incorporated into Strengthening Family Coping Resources through a variety of family and age-based activities.

Strengthening Family Coping Resources is comprised of three modules. The first module includes three 2-hour sessions and introduces family rituals and routines through activities such as telling family stories and creating a family ritual tree. Additionally, routine is created within the group by starting each session with a family dinner, and developing a consistent opening and closing ritual activity for each session (e.g., relaxation activity, giving thanks). The second module includes six sessions that focus on building coping resources. This module helps families enhance their feelings of safety, draw on resources to build social support, plan and carry out family activities, and use their spirituality as a means of understanding what is important to them. Over six sessions, the third and final module uses the family's enhanced coping skills to support work focused on the family trauma history. Together, family members create a trauma narrative to work through their trauma(s) and develop a shared sense of meaning. The final session is a celebration of all the families' hard work, and highlights the importance of observing positive events. Although the current version includes 15 sessions, earlier versions included only 14 sessions. An additional session was added to Module 3 to allow more time for families to complete their trauma narratives. Additional, smaller changes have been made to session content or activities over the course of multiple administrations of the intervention based on feedback from facilitators and the families who participated.

To implement Strengthening Family Coping Resources, a facilitator team is required to lead the intervention, including a lead facilitator and multiple cofacilitators. The number of facilitators is based on how many are needed to staff age-based small group activities and help manage the large number of participants of varying ages. For the pilot study, the intervention was delivered onsite at the participating outpatient clinics.

RESULTS

Attendance and Participation

Families participated in either a 14- or 15-week version of Strengthening Family Coping Resources. Eight groups were conducted over the course of 36 months with an average of four families initially enrolled in each group. Families actively engaged and participated in Strengthening Family Coping Resources as evidenced by 53% completion rates, average attendance at 85% for families who completed the group, and over 50% completion of homework assignments. The completion rates for Strengthening Family Coping Resources are comparable to other clinics serving low-income, urban populations. For example, one study found that 64% of child patients identified as in need of mental health treatment were brought in for an intake appointment, and only 54% of those children who were brought in attended at least eight sessions (McKay, Pennington, Lynn, & McCadam, 2001). In our study, there were no significant differences between the families who completed Strengthening Family Coping Resources and those who dropped out based on age, gender, and race/ethnicity of the parent or child.

Families completed satisfaction questionnaires at the postassessment. The questionnaire includes items related to treatment enjoyment, the family's participation in treatment, the

relationship between the family and the therapists, and the skills they learned. Families rated the items on a 5-point scale, with higher ratings indicating stronger agreement with the statements. Overall, families reported high satisfaction with the intervention. The item means ranged from 3.89 ($SD = 0.96$) to 4.78 ($SD = 0.43$). Families stressed the importance of what they learned with comments such as “Maintaining our life in spite of the tragedy,” “Our family learned to use skills that may be needed in the future,” and “We are not alone; everybody has problems.”

Treatment Fidelity

Each session was videotaped for further full review and 10% were randomly chosen and monitored for clinician competence and adherence. Fourteen sessions were rated by two independent coders for facilitator competence and fidelity to the treatment manual. The clinician competence measure included 14 items such as “Carried out activities in an organized fashion,” “Empowered parents to maintain control of their children,” and “Facilitated the group’s practice of rituals.” Ratings were made on a 5-point Likert scale, ranging from *rarely* to *most of the time*. Facilitators demonstrated clinical competence in conducting the groups (average rating 4.3 out of 5 or *most of the time*). The measure of fidelity included 16 items related to session content in which raters coded yes, no, or not applicable. Trained facilitators were successful at maintaining the structure of the groups and introducing the content as stipulated in the manual (92% compliance).

Child Outcomes

Preliminary indications of change were assessed using pre- and postmeasures. Postintervention change was assessed with t tests for dependent samples. Cohen’s d was used to calculate effect size. Children demonstrated significant reductions in overall PTSD symptoms, reexperiencing, and arousal symptoms. Children also demonstrated significant reductions in internalizing symptoms, including anxiety and depression, social problems, aggressive behaviors, and attention problems as reported on the Child Behavior Checklist. The results are presented in Table 1.

DISCUSSION

Results of the open trials demonstrate the feasibility of Strengthening Family Coping Resources. Although the data are limited, initial support for Strengthening Family Coping Resources indicates the intervention succeeds at delivering a unique combination of treatment components within a multifamily group format. Participant completion rates, attendance, and intervention satisfaction provide evidence of the intervention’s acceptability and tolerability among low-income, urban families. This is an important finding given that daily hassles, multiple environmental stressors, and chronic trauma often jeopardize the capacity of families to effectively use structured treatment approaches and limit the effectiveness of treatments that require family support. Rates of attendance and completion found were substantially higher than demonstrated in other studies of adherence with similar samples (Snell-Johns et al., 2004).

Results from pre- and postassessments demonstrate improvements in children’s functioning, including decreases in PTSD symptoms and other behavioral and emotional concerns. Moreover, feedback from participants suggests that Strengthening Family Coping Resources is effective in positively reframing the traumatic experience for families, increasing collaborative coping, and strengthening the sense of connectedness among family members.

Use of the pre- and postdesign with feedback from families and clinicians, as well as the data acquired from each group, provided the opportunity to modify the Strengthening

Family Coping Resources manual, clinician training protocol, and materials to address limitations and maximize the benefits to families who participate. For example, based on clinician feedback, the initial 14-week version was modified by adding a session around structuring the family trauma narrative to better harness the power of this treatment component.

Completion of Phase II of NIDA's model with promising results sets the stage for Phase III, a randomized clinical trial to test the efficacy of Strengthening Family Coping Resources. Such a trial would address many of the limitations of the current preliminary study including small sample size, lack of comparison condition, no correction for multiple comparisons, and limited data on the response of other family members or subsystems (i.e., parenting).

Acknowledgments

This research was supported by grants from the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration.

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Summary of Pre- and Postfindings

Table 1

Measure	Scale	Pre		Post		Effect size ^d
		M	SD	M	SD	
KSADS P/L	Last week PTSD	39.96	12.17	30.84	14.66	0.71**
	Last week reexperiencing	15.88	6.41	11.92	7.29	0.66 ^a
	Last week avoidance	12.36	4.12	10.16	4.94	0.42
	Last week arousal	11.63	3.03	8.63	3.61	0.94***
CBCL	Anxious/depressed	62.63	10.13	58.68	9.76	0.55*
	Withdrawal/depressed	56.79	20.81	52.84	19.60	0.68**
	Somatic complaints	58.53	9.51	56.00	7.53	0.31
	Social problems	58.84	21.92	54.26	20.46	0.67**
	Thought problems	55.05	21.50	52.84	20.33	0.34
	Attention problems	67.11	11.54	62.21	9.24	0.63*
	Rule-breaking behavior	59.21	22.51	57.74	22.40	0.22
	Aggressive behavior	71.26	11.49	67.42	11.53	0.52*
	Internalizing	62.21	10.79	55.84	13.41	0.66*
	Externalizing	68.26	11.30	65.16	13.45	0.46
	Total problems	66.58	10.98	62.32	13.01	0.54*

Note. $N = 19$. The Schedule for Affective Disorders and Schizophrenia for School Age Children- Present (K-SADS P/L) could not be used for three children in the sample due to age restrictions of the measure and logistical constraints at one treatment site. Therefore, trauma symptom reports were taken from either the Trauma Symptom Checklist for Young Children (TSCYC; Briere et al., 2001) or the UCLA PTSD Index (Steinberg et al., 2004). Scores on the TSCYC and UCLA PTSD Index were transformed and included with the K-SADS scores reported. Age appropriate versions of the Child Behavior Checklist (CBCL) were used. PTSD = posttraumatic stress disorder.

^a m_z/σ_z , where $z = \text{post} - \text{pre}$.

* $p < .05$.

** $p < .01$.

*** $p < .001$.