Strengthening Family Coping Resources (SFCR)
Frequently Asked Questions

**What is SFCR?**

Strengthening Family Coping Resources (SFCR) is a manualized, trauma-focused, skills-based intervention which uses a multi-family group format.

**What versions of SFCR are available?**

There are three versions of SFCR currently available.

The trauma treatment model is a 15-week group with closed enrollment. This version of SFCR is designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder (PTSD) and other trauma-related disorders in children and adult caregivers. Since most families living in traumatic contexts contend with on-going stressors and threats, SFCR is also designed to increase coping resources in children, adult caregivers, and in the family system to prevent relapse and re-exposure. SFCR provides accepted, empirically supported trauma treatment within a family format. SFCR includes additional therapeutic strategies designed to improve the family’s ability to cope with on-going stress and threats of re-exposure. Specifically, SFCR builds the coping resources necessary to help families boost their sense of safety, function with stability, regulate their emotions and behaviors, and improve communication about and understanding of the traumas they have experienced. A number of families are recruited for enrollment, assessed for appropriateness and selected to participate in all weekly 2-hour sessions over the 15 week period. The trauma-specific model is for families who have been exposed to trauma(s) and are experiencing symptoms of traumatic stress.

The high-risk model is a 10-week multifamily group with closed enrollment. Similar to the trauma-specific model, a number of families are recruited for enrollment, assessed for appropriateness and selected to participate in all weekly 2-hour sessions over the 10 week period. The high risk model is more appropriate for families at risk for exposure to trauma or for families who have experienced trauma but have minimal symptoms of traumatic stress. The primary difference between the trauma-specific model and the high-risk model is that the high-risk model does not include the 5-week module in which families co-construct a trauma narrative. All 10 sessions included in the high-risk model are also included in the trauma-specific model.
The third version is a workshop model with open enrollment, in which families can drop in for any number of sessions. The workshop model covers essentially the same content as the 10 week high-risk version, with some adaptations made for the different format.

**Who should take part in SFCR?**

The selection criteria for the group vary with the format.

For the 15-week trauma treatment model, exposure to a traumatic event and associated traumatic stress symptoms are a requirement for eligibility. More specifically, at least one member in the family, must have experienced multiple traumatic events which meet Criterion A for a DSM-IV PTSD diagnosis. In addition, the identified family member(s) must also meet criteria for a full or partial diagnosis of PTSD.

The selection criteria for the high-risk model are less stringent. It is common for families who participate in this model to have experienced traumatic events or live in environments where the risk for exposure to trauma is high. Additionally, traumatic stress symptoms may be present at a subclinical level.

The workshop model is typically offered by organizations serving families at high-risk for trauma exposure. These organizations typically either select or recruit families to participate in the workshop by advertising the workshops and inviting any interested family to drop in and participate.

**How do you engage families in this treatment approach? How do you ensure/create group cohesion amongst group members?**

Issues of family engagement and retention are critical to intervention effectiveness for the targeted families for two reasons: a) previous trauma treatment research with children and their families demonstrate that the symptoms of the disorder (isolation, mistrust) may impede the establishment of therapeutic alliances; and b) families living in traumatic contexts may have cultural, logistical, and financial issues that impede engagement. Therefore, significant efforts are made to identify and minimize barriers to recruitment and to encourage attendance and participation. SFCR is highly structured and manualized. Even so, it is critical to establish rapport and a good working relationship with each family. This requires clinical skills and an investment in engaging each family in the treatment process.

SFCR has several specific strategies built in to help increase engagement. These include providing a meal at each session, fun activities, and reminder phone calls and postcards from facilitators to encourage ongoing participation. Individual sites may offer additional incentives, as available, such as transportation to/from sessions and providing a door prize to at least one family at each session.
An important part of the intervention and engagement in SFCR is the formation of a community among group members. In the first session, families work together to determine their opening and closing rituals, providing them ownership over their group. Over the course of SFCR, families are asked to share stories and other activities with the group (although they are never asked to share any information about their traumas with the group). These group activities allow the relationships between families to grow. Breakout groups divided by age also help with group cohesion. The parent breakout group is often critical to the families’ engagement in the treatment process. Parents often form a close bond that seems to be an important factor in their level of engagement. Additionally, the youth are given a chance to spend time with other kids their age and do a fun activity together. Also, in session 6, a family buddy system or phone tree is established so families can contact one another outside of sessions. This serves to both support participation in group and group cohesion among members.

**How do you measure fidelity? Is there videotaping involved?**

After each session, each facilitator completes a treatment adherence measure. The adherence measure uses a yes/no question format. The measure includes 16 items indicating both actions and procedures, as specified in the treatment manual, which a clinician should and should not be doing during each session.

Videotaping can be used, at the discretion of each site, to aid in ensuring fidelity. However, videotaping is not a requirement for measuring treatment fidelity.

**How is SFCR staffed?**

SFCR groups are conducted using facilitator teams. SFCR facilitator teams usually comprise experienced clinicians along with students or other support staff.

**What clinical or other competence is required for the facilitators to be effective?**

Generally, to implement SFCR, clinical facilitators should be trained in developmental psychopathology, and be experienced in assessing and treating a wide range of different child, adolescent, and adult mental health disorders within the context of the family. Additionally, clinical facilitators should have prior training and supervision in providing a variety of treatment approaches to children and their families, both individually and in groups, including: family systems, parent-child interaction, cognitive-behavioral, and play therapies. Clinical facilitators should also have experience in the provision of trauma-focused treatment with children and their families.

SFCR provides a wonderful training opportunity for students from a variety of mental health disciplines. Students who serve as part of a SFCR facilitator team have the opportunity to observe the clinical facilitators work with a variety of families in a variety of clinical modalities
(multi-family, family, and small group) and also participate in leading various group activities under close supervision.

Additional facilitators can be members of the organization or community in which the group is taking place and bring an understanding of that community’s culture and value system.

More specifically, the facilitators are required to maintain a focus on specific issues related to constructive family coping. They attend each session with a positive attitude and high expectations. They make the children, the caregivers, and the families as a group feel that this time is special. They encourage each group to form a network and make positive use of all of the people resources available during each session. When events happen to threaten the continuity or cohesion of the session, the facilitators model flexible problem-solving skills and conflict resolution, yet manage to ensure that the session proceeds and the goals for the session are accomplished. Finally, they encourage a high level of participation from each person attending regardless of their age, stage of development, or abilities.

In addition, facilitators must be sensitive to the needs of trauma victims. They are aware of the physiological and emotional reactions that are triggered by reminders of traumatic events and work to identify these triggers and help participants regulate their expressions of distress. Facilitators are also keenly aware of the contagious nature of traumatic distress so pay careful attention to group processes. Finally, facilitators realize that trauma treatment is difficult and make efforts to work through their own reactions to the trauma pain that is experienced within the group.

**What is the minimum number of facilitators required or is there a recommended ratio?**

The minimum number of clinical facilitators required for the trauma-specific and high-risk models are based on two factors: the total number and size of families enrolled and the number and size of age-based breakout groups.

For the trauma treatment version, at least one clinical facilitator must be present for each family enrolled in the group to cover the family-based breakout groups (co-constructing a family narrative). For these family narrative sessions it is important that each facilitator is skilled and comfortable in conducting trauma-focused family therapy. If meeting this requirement is a challenge due to staff restrictions, there are some possible ways to alter the group schedule to accommodate fewer experienced clinical facilitators. Such modifications are addressed on a site-by-site basis.

At least one facilitator must be present to cover each age-based breakout group. Possible groups outlined in the SFCR manual include: parents, adolescents, older children, younger children, and babies and toddlers. However, there are several considerations which may alter the number of facilitators required. First, not all groups will have children to fill each age-based
breakout group. For example, there may not be any adolescents enrolled so a facilitator is not required to staff this group. Second, some sites recruit families with children of specific ages to limit the number of breakout groups (either due to space or staff limitations). For example, one site did not recruit families with babies or toddlers because they were unable to staff this breakout group.

Finally, some breakout groups may need more than one facilitator to manage the group appropriately. This may be due to the age of the children, the number of children included in the group, and/or behavior concerns. Traditionally, breakout groups benefit from additional staff if there are several babies, toddlers, or young children, or if there is a child who has difficulty managing his/her behavior and may be disruptive to the other members of the group.

For the workshop model, approximately 2-3 facilitators are required given a group size of 4-5 families.

**How much non-direct time does it typically take to prepare for group?**

Preparation for the group involves several components: initial preparations prior to session one, meal preparations, and preparing for each session on a week-to-week basis. The initial prep, especially if it is the first time a site is running the group, can be fairly time-intensive. The preparation includes ordering or shopping for all group materials, recruiting families, preparing the weekly materials, and organizing the facilitator team and other logistics (such as space, food, etc). However, many of these tasks can be divided among several individuals and are started 4-8 weeks prior to the group start date, decreasing the burden on one person’s schedule.

The extent of the mealtime preparations depends on what type of meal your site is able to implement, how the delivery of the food is arranged, and how you plan to serve the food (see below for more information). Weekly tasks may include ordering the food, picking up the food or arranging to meet a delivery person, setting up the room for mealtime (i.e., setting up the buffet, setting the tables), and cleaning up after the meal.

Lastly, the week-to-week preparation for sessions includes two main tasks: meeting as a group for supervision and planning purposes, and prepping the materials for the impending session. Typically, groups meet for 30 minutes to an hour to discuss the previous group, debrief and problem solve any difficulties that were not handled in session. The team also plans for the next session, including assigning various roles, as needed, and plans for any clinical concerns (i.e., how the team will handle a disruptive child). The material preparations are typically assigned to one or two individuals for the duration of the group. These tasks include printing/coping all handouts and gathering materials for each of the planned activities. The amount of time to complete these tasks varies based on the individual’s experience with the group materials and the nature of the activities planned for that session. Typically, these tasks can take anywhere from 10 minutes to 45 minutes.
What are the costs associated with the supplies necessary for conducting the group?

The cost for the supplies is outlined in the last two pages of the SFCR manual. For the full 15-week version, the cost for supplies is currently around $1800. These supplies are predominantly reusable, and will be a one-time cost. However, there will also be an ongoing cost related to food, which depends on the size of the group and the type of meal provided. For the high risk version, several of the supplies used in the full version are not needed. These are indicated on the order form with an asterisk and decrease the cost by approximately $250. The meal component is also included in this version, but only requires 10 weeks of food costs. The materials needed for the workshop model vary by the materials available at each site. A projected list of supplies and possible cost can be provided upon request.

What time of day do you hold groups?

The time of day can be determined by your site, depending on staff availability, space availability, and when families are most likely to attend. Our groups have previously been conducted in the morning, afterschool, and early evening hours. Most commonly at our clinic, the full trauma model is run in the early evening and a family dinner is served. The morning and early afternoon groups have primarily been used with the workshop model.

Can you describe the meal component? What type of food do you serve? What is the cost?

The meal component usually consists of a dinner, which can be served and consumed within the 30-minute time frame allotted to the family meal. At our center, the dinners typically include kid-friendly meals that change from week-to-week. Meals have included spaghetti, chicken fingers and French fries, grilled cheese and soup, hamburgers, pizza, etc. Meals may either be served family style, in which there is a portion large enough for the entire family set at the center of each family’s table, or as a buffet. Typically, the manner of serving the meal is based on the availability of space at each individual site.

Several groups have served breakfast or an afternoon snack instead of dinner. The type of meal served is influenced by the time of day during which you will be running the group and at times, the model of the group being used. The workshop version tends to be most flexible in terms of scheduling, and often lends itself to being run at various times during the day. Therefore, in our experiences, the workshop version has served the greatest variety of meals.

The type of the meal you are able to serve and the cost will likely be determined by the options available to your institution. For example, at our clinic, we have an arrangement with a local restaurant for a set cost per person, providing we select the meals from a limited menu.
Can you explain the space requirements? How many breakout rooms are needed? How often are breakout rooms needed? How big?

To implement the full trauma or high-risk versions of SFCR, a large group room is required that can accommodate all of the families who are members of the group, the facilitators, and serving a family meal.

In addition, several smaller rooms are required for the breakout groups. The number of “breakout” rooms required depends on the number of breakout groups within each group and/or the total number of families enrolled. For the age-based breakout groups, each group requires their own space to complete their activities with a facilitator. The maximum number of breakout groups is 5; parents, adolescents, older children, younger children, babies & toddlers. For the family-based breakout groups, each family requires their own space to complete their activities. The number of rooms required depends on the number of families recruited and enrolled. A typical therapy office is usually large enough to accommodate the breakout groups, although it depends on the number of participants in each group.

It is important to note that at many sites, the space requirements are strongly considered when recruiting for the group. If space limitations are present, facilitators will only recruit and enroll the number and size of families they are able to accommodate with the space they have available. Additionally, if needed, several sites have limited their recruitment to families with children in specific age ranges to limit the number of breakout groups.

What is the cost of ongoing training and consultation? How is the initial training and ongoing consultation handled?

Implementation for SFCR consists of a pre-implementation planning phase followed by formal training and ongoing consultation. Training includes didactics covering constructive family coping, family traumatic stress, and intervention content delivered as a 2-day workshop. All intervention methods and materials are presented in detail, including discussion of each session, rehearsal through role-plays, and hands-on practice of several activities. On-going consultation consists of weekly calls with the facilitator team through one 15-week group and bi-weekly calls through the second 15-week group. Consultation is typically conducted via conference calls pre-arranged at a regular weekly time that is convenient for both Dr. Kiser and the facilitator team.

Costs vary depending on the version of SFCR being used and the number of teams being trained. The initial training can be held locally at your site, although the overall cost will increase to include travel expenses.