GROUP TREATMENT WITH CHILDREN EXPOSED TO DOMESTIC VIOLENCE

BY

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ABSTRACT

Empirical research suggests that children who have witnessed domestic violence exhibit internalizing and externalizing symptoms as a result. Research also suggests that group treatments are a beneficial modality when working with this population of children.

This practicum involved facilitating two twelve-week group treatment programs for children between the ages of seven and eleven years who had been exposed to domestic violence. One group included a multifamily component where the mothers were an integral part of the therapeutic process. The other group did not include a formal parental component. The intervention utilized a developmental psychopathology framework with the underpinnings of social learning theory, attachment theory, and trauma theory as guides for the intervention and evaluation. Outcomes indicated various levels of success ranging from minimal to high. An important finding was that the inclusion of mothers in the therapeutic process appeared to be beneficial in improving the presenting symptoms of the children.

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Chapter I Introduction

Introduction/Rationale

Direction for this paper emerged from the empirical and clinical literature regarding the impact on children of witnessing domestic violence, and the lack of research in this relatively new topic area. Research has shown that children who have witnessed domestic violence display many maladaptive symptoms that often result in devastating impacts on their lives (Fantuzzo, DePaola, Lambert, Martino, Anderson, & Sutton, 1991; Graham-Bermann & Levendosky, 1998; Holden & Ritchie, 1991; Huth-Bocks, Levendosky, & Semel, 2001; Wolak & Finkelhor, 1998; Wolfe, Zak, Wilson, & Jaffe, 1986). Symptoms include externalizing behaviors, internalizing behaviors, impaired peer relationships, poor school performance, and signs of trauma. In addition to affecting their current situation, there has also been evidence of long-term impacts. According to the intergenerational transmission of violence theory, child witnesses may transfer the roles of the perpetrator or the victim into their adult relationships (Straus, Gelles, & Steinmetz, 1980). Although evidence continues to emerge indicating the adverse effects of witnessing domestic violence on children of battered women (Edleson, 1999; Fantuzzo et al., 1991; Graham-Bermann & Levendosky, 1998; Holden & Ritchie, 1991; Huth-Bocks et al., 2001; Rossman, 2001; Wolak & Finkelhor, 1998; Wolfe et al., 1986), research appears to be in the beginning stages of identifying effective solutions. Compared to the number of programs and services for battered women, there are few interventions in place for children of battered women (Jaffe, Wilson, & Wolfe, 1986).

Interventions that have been applied to this population include individual play therapy, Theraplay (Jernberg, 1979), group therapy (Siepker & Kandaras, 1985), parallel parent and child group therapy (Gaines, 1986), and combinations thereof. Of the therapeutic methods mentioned, group interventions have resulted in promising outcomes (Peled & Edleson, 1992; Wagar & Rodway, 1995) such as improving children's internalizing and externalizing behavior problems. Empirical research on group work with child witnesses however has been scarce, and methodological shortcomings limit the conclusions that can be made from the studies completed thus far. Of the evaluations completed, many are not based on an adequate sample size, many do not have control groups, and group participants have been obtained mainly from the shelter population of children, which renders an unrepresentative sample.

Additional research in this area is important in order to build the knowledge base and to understand and decrease the many debilitating effects on children. This practicum explores the application of group work with children who have been exposed to domestic violence as a way of alleviating their internalizing and externalizing behaviors, and as a way of expanding the knowledge base in the area.

Learning Objectives

My learning objectives for this practicum included the following:

1. To obtain more information on the topic of domestic violence and how it impacts children.
2. To implement and evaluate a group treatment program for children who have been affected by witnessing domestic violence.

3. To acquire new knowledge about clinical group practice with children impacted by family violence, and to enhance my clinical skills in the group setting.

Client-focused Objectives

Client-focused objectives for this practicum included the following:

1. To educate the children in the group about family violence and provide them with techniques and strategies that they may apply outside the group setting.
2. To provide a safe environment where children could understand their feelings and learn new more adaptive behaviors.
3. To make positive changes with respect to the behavioral and/or emotional problems the children presented.

Chapter II Review of the Literature

Prevalence and Incidence of the Problem

It has been estimated that between 3.3 million (Carlson, 1984) and 10 million children (Straus, 1992) in the United States are at risk of witnessing domestic violence[1] each year. In Canada, during a one-year period ending in March 2000, an estimated 57,200 women together with their 39,200 children were admitted to 448 shelters (Juristat, 2001). In a 5-year period between 1994-1999, results from the 1999 General Social Survey on Victimization (GSS) estimated that children heard or saw domestic violence in 461,000 households, which represented 37% of all households with spousal violence. The 1993 Violence Against Women Survey (VAWS) found that 39% of women who had experienced domestic abuse reported that their children had witnessed the violence against them. In addition, according to the 1998-1999 cycle of the National Longitudinal Survey of Children and Youth (NLSCY), 8% of children aged 4-11 experienced violence in the home. This percentage converts to approximately 247,000 children (Juristat, 2001).

In a study completed by Holden and Ritchie (1991), mothers in a women's shelter were asked questions regarding the effects of abuse perpetrated on them by their partners, and how this impacted their children. Seventy-eight percent of the mothers reported that their children were aware of abusive episodes most of the time, and that

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[1] In this paper, the terms "domestic violence" and "family violence" will be used interchangeably, as the fighting that occurs between the couple affects the entire family.

their children witnessed abuse against them once every few weeks. Making these figures even more staggering is the finding that many mothers underestimate the extent to which they are being abused (Straus et al., 1980), and they also underestimate the amount of abuse that their children witness (Juristat, 2001). These statistics attest to the high numbers of children who are witnesses to domestic violence.

Effects of Witnessing Domestic Violence on Children

The experience of domestic violence for children goes beyond witnessing the violence visually, and includes an all-encompassing exposure to domestic violence (Jaffe, Wolfe, & Wilson, 1990). A child may routinely hear the sounds of screaming, yelling, loud thumps, or objects breaking for example, or regularly see bruises or cuts on his or her mother's face and body. In addition, police intervention or calls for an ambulance may be common place, as well as stays in a women's shelter (Edleson, 1999). These constant upheavals and distractions in a child's life have been shown to have adverse effects on children.

Children may be affected on many levels as a result of their exposure to domestic violence. These effects may be seen in externalizing and internalizing behaviors, disruptions in physical, intellectual, cognitive, and social functioning, as well as traumatic symptomology (Fantuzzo et al., 1991; Graham-Bermann & Levendosky, 1997, 1998; Holden & Ritchie, 1991; Huth-Bocks et al., 2001; Wolak & Finkelhor, 1998; Wolfe et al., 1986). In addition, there may be long-term developmental problems (Edleson, 1999; Rossman, 2001). The heterogeneous nature of this population should be noted, as not all children are impacted in the same way. In fact,

some children cope successfully despite the adverse family violence experiences they have had (Wolak & Finkelhor, 1998), while others experience critical levels of some or all of these symptoms. In a study completed by Hughes and Luke (1998), variations in distress levels and heterogeneity in adjustment were found to exist for a group of child witnesses to domestic violence. A brief elaboration of common possible symptoms is outlined next, the origins of which vary according to which explanatory theories are used. Explanatory theories will be covered in a later section.

Externalizing

Externalizing behaviors seen among children exposed to domestic violence may include aggression, temper tantrums, acting out, immaturity, truancy, and delinquency (Wolak & Finklehor, 1998). According to Rosenberg and Rossman (1990), abused mothers rate their children as more aggressive and more hyperactive than children from non-abusive families. In a study completed by Ware, Jouriles, Spiller, McDonald, Swank, and Norwood (2001), it was revealed that 30% of their sample of children were reported by their mothers to have clinical levels of externalizing behavior problems. Another study found that 21% of child witnesses demonstrated externalizing problems (Grych, Jouriles, Swank, McDonald, & Norwood, 2001).

In a study completed by Holden and Ritchie (1991), when compared to a group of children who had not been exposed to violence, children of battered women developed more behavior problems, had more difficult temperaments, and were more physically aggressive. In a study completed by Fantuzzo et al.(1991), a direct relationship between inter-parental conflict and child adjustment problems was found. Children who were exposed to both physical and verbal abuse exhibited higher levels

of externalizing behavior problems than a group of children not exposed to any violence. They also displayed clinical levels of conduct problems. In a study that considered husbands' reports as well as reports from mothers, it was revealed that husbands' marital violence was associated with externalizing behaviors of children (McDonald, Jouriles, Norwood, Ware, & Ezell, 2000).

Internalizing

Forms of internalizing that children may experience include anxiety, depression, low self-esteem, anger, and withdrawal (Wolak & Finkelhor, 1998). In a study completed by Holden and Ritchie (1991), children of battered women experienced impaired interpersonal relations, emotional problems, were clinically distressed, and had a higher incidence of internalizing problems than a comparison group. Grych et al. (2000) found that 18% of their sample of children experienced internalizing behavior problems and McDonald et al. (2000) found that husbands' marital violence was associated with child internalizing problems.

Physical Functioning

Children may be affected physically in many ways including failure to thrive, sleeplessness, regressive behaviors, eating disorders, poor motor skills, and psychosomatic symptoms, such as eczema and soiling (Moore, Galcius, & Pettican, 1981; Wolak & Finkelhor, 1998).

Intellectual and Cognitive Functioning

School adjustment difficulties including intellectual and cognitive functioning are at times impaired in child witnesses and may result in poor academic performance and language lag (Jaffe et al., 1990; Wolak & Finkelhor, 1998). In a study completed

by Huth-Bocks et al. (2001), which examined the direct and indirect effects of domestic violence on children's intellectual functioning, it was concluded that witnessing domestic violence had a direct effect on children's intellectual functioning. The authors concluded that children who had witnessed domestic violence within the last year had poorer verbal abilities when compared to a group of non-witnessing children. In addition they concluded that family violence impacts maternal depression, which leads to a less intellectually stimulating home environment, thereby indirectly impacting the intellectual abilities of children from abusive families.

Social Functioning

Children's social functioning may be impaired as a result of witnessing domestic violence as well (Jaffe et al., 1990). Research has shown that these children score below their peers in areas reflecting social competence, including school performance, organized sports and activities, and social involvement (Moore & Pepler, 1998; Wolfe et al., 1986). In a study by Fantuzzo et al. (1991), it was concluded that children who had been exposed to verbal and physical conflict and who had spent time in a shelter, had the lowest levels of social functioning when compared to other children their own age. Graham-Bermann and Levendosky (1997) found that children of battered women had a difficult time interacting with peers socially in that they exhibited more negative affect, responded less appropriately to situations, and were more aggressive with peers. However it was also found that these children engaged in happy, mutual, and cooperative play, they shared with

others and took their turns, and joined in play with others (Graham-Bermann & Levendosky, 1997).

Traumatic Symptomology

Symptoms that are indicative of post-traumatic stress disorder (PTSD) as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2000) may occur as a result of certain physical dangers that children are faced with in a violent home. Witnessing an event involving injury or the threat of death, plus intense fear and helplessness, characterize part of the DSM-IV classification of PTSD. Additional characterizations include irritability and outbursts of anger, flat affect, and repetitive play that symbolizes aspects of the traumatic event. Research suggests that children who are exposed to domestic violence often exhibit PTSD symptomology (Graham-Bermann & Levendosky, 1998; Jaffe et al., 1990).

In a study completed by Graham-Bermann and Levendosky (1998), children who witnessed domestic abuse between their parents developed symptoms that suggested PTSD. Within their study, 13% of the children qualified for a complete PTSD diagnosis. In addition, 52% of the children encountered "intrusive re-experiencing", 19% had "persistent avoidance symptoms", and 42% experienced increased "traumatic arousal symptoms", all of which are symptoms of PTSD.

Long-Term Effects

As a result of the interruption of normal development, children may suffer long-term effects of witnessing domestic violence. According to Rossman (2001), exposure at any age to domestic violence can upset the regular progression of development, and earlier exposure may create even more interruptions by disrupting

the "subsequent chain of developmental tasks" (Rossman, 2001, p. 58). In addition, children who live in a physically and verbally abusive home may learn these behaviors and apply them in their own adult relationships. Therefore, taking on the role of the perpetrator or the victim in adulthood may be another long-term effect (Straus et al., 1980).

In the following section, a developmental psychopathology model will be discussed, followed by a review of social learning theory, attachment theory, and trauma theory, all of which link witnessing family violence and negative symptoms exhibited by children.

A Developmental Psychopathology Framework

As a result of witnessing family violence a child's normal pattern of development may be disrupted. This may increase his or her risk for the development of psychopathology (Cummings, 1998; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003) and may result in "disturbed patterns of cognitive, emotional, and/or behavioral adjustment" (Jaffe et al., 1990, p. 39). Throughout this practicum, a developmental psychopathology framework was used to assist in the understanding of the impacts of witnessing family violence upon children. The topic of family violence from a developmental psychopathology perspective is an interrelated complex process involving many factors, as opposed to a linear process of cause and effect (Graham-Bermann, 1998; Wolfe et al., 2003).

Cummings (1998) explains that a developmental psychopathology perspective "emphasizes dynamic processes of interaction between multiple intra- and extra-organismic factors" (p. 67). Sameroff (2000), as a way to organize and explain the

multitude of influences acting upon a child's development, suggests a "model of transactional development" (p. 309). In the model, Sameroff (2000) explains that there is constant interaction between the "phenotype", or the child, the "environtype", or the source of external social and cultural experience, and the "genotype", or the biological processes of the child. Their interaction with each other results in the developmental outcome of the child. Levendosky and Graham-Bermann (2001) found that an ecological model, which took into consideration the indirect environmental factors impacting women and children, was more relevant when discussing the impact of domestic violence upon women and children when compared to a direct effects model. Some factors they used in their model included maternal history of child abuse, negative life events of the mother, and lack of social support.

Important in a developmental psychopathology framework is the notion that there are many risk and protective factors that are present for children living in high-risk families that impact a child's development (Cummings, 1998; Graham-Bermann, 1998; Wolfe et al., 2003). All of these factors interact with and react to each other, eliminating the possibility of a linear cause-effect model (Cummings, 1998; Graham-Bermann, 1998; Rutter & Sroufe, 2000; Sameroff, 2000; Wolfe et al., 2003). In fact the outcomes cannot be placed into neat categories, but rather lead to a heterogeneous population (Rutter & Sroufe, 2000). Knowledge of the multiple factors will be important for effective assessments and interventions (Sameroff, 2000).

Some risk factors that influence a child's development include the parent-child attachment, family events and relationships outside the parent-child system, child characteristics, and the child's coping responses and style (Cummings, 1998). In

addition, social and cultural factors are important in predicting the developmental outcome of a child (Sameroff, 2000; Wolfe et al., 2003). Also, a history of maternal mental illness, high maternal anxiety, rigid attitudes, beliefs, and values held by parents, few positive interactions between mother and child during infancy, unskilled occupations held by the head of household, minimal maternal education, disadvantaged minority status, single parents, stressful life events, and large family size may all impact a child's development (Hughes, Graham-Bermann, & Gruber, 2001; Sameroff, 2000).

Risk and protective factors may come in the form of direct or indirect influences on the child (Jaffe et al., 1990; Wolak & Finkelhor, 1998; Wolfe et al., 2003). Direct effects may include exposure to and learning of aggressive behavioral patterns, exposure to physical danger, and emotional and behavioral problems that ensue as the child attempts to cope with his or her environment (Jaffe et al, 1990; Wolak & Finkelhor, 1998). Indirectly the child may be influenced by maternal stress, paternal irritability, disciplinary practices of his or her parents, and exposure to parental anger and agitation (Jaffe et al, 1990; Wolak & Finkelhor, 1998). In a study by Levendosky and Graham-Bermann (1998), it was shown that children are impacted directly through the observations of the violence, and indirectly through the effects on the stress of the mother. The combination of factors impacting upon a child, both direct and indirect, contribute to the overall level of functioning of the child (Cummings, 1998).

The factors just mentioned help to explain how some children are impacted by family violence. However, why do some children emerge with clinical problems and

others emerge with a healthy level of functioning when faced with similar levels of dysfunction in their families? There are certain moderating factors that appear to affect the degree to which a child is impacted by family violence (Jaffe et al., 1990; Wolak & Finkelhor, 1998). The age and developmental level of the child is one moderator, with violence having varying degrees of impact at different stages in a child's life (Jaffe et al., 1990; Wolak & Finkelhor, 1998; Wolfe et al., 2003). For example, infants may be more vulnerable as their need for attachment may be disrupted by the violence, and adolescents may be impacted as they are at risk of repeating the patterns seen in their homes within their own intimate relationships (Jaffe et al., 1990). Therefore, depending on the age of the child, they will be more or less vulnerable to being impacted by family violence.

The nature and severity of the violence that a child has witnessed may also be a moderator, with increased and more violent incidents suspected as having a greater impact on the child (Wolak & Finkelhor, 1998). In a study completed by Hughes, Parkinson, and Vargo (1989), it was concluded that children who had been witnesses to family violence as well as victims of abuse themselves exhibited more behavior problems when compared to children who had only witnessed violence, and when compared to a comparison group.

Another moderator includes the family context of the violence, or other stresses that are occurring alongside family violence. Also, the nature and impact of the social interventions that the family utilizes, such as access to a local women's shelter or to the police (Wolak & Finkelhor, 1998), and the gender of the child (Jaffe et al., 1990) help to dictate the impact of violence on the child. Some research suggests that

boys and girls experience different levels of problems. According to a study completed by Moore and Pepler (1998) girls in a shelter were significantly more poorly adjusted in the areas of internalizing problems, externalizing problems, and social competence than boys in the shelter.

Therefore, children have a multitude of risk factors and moderators that contribute to their overall level of functioning, with more risk factors increasing the chances for a higher incidence of clinical symptoms (Sameroff, 2000). However, there are also some protective factors that have been highlighted in the research that play a role in the child's developmental outcome. Cummings (1998) and Graham-Bermann (1998) note the importance of being aware of protective factors. Protective factors add to the resiliency of children and may be important for understanding this population, for planning interventions for this population, and for future research with this population (Cummings, 1998; Graham-Bermann, 1998; Hughes, Graham-Bermann, & Gruber, 2001). Sameroff (2000) notes that protective factors are the same as risk factors, but at the positive end of the continuum. For example, if a parent's poor mental health is a risk factor, then good mental health would become a protective factor. The more protective factors present for a child, the higher the incidence of healthy functioning (Sameroff, 2000).

According to Jaffe et al. (1990) and Wolak and Finkelhor (1998) research identifies three main protective factors that may lead to the resiliency in some children. One factor includes the characteristics or attributes of the child that may serve to protect him or her from the negative outcomes of witnessing violence in the family. A child who is intelligent for example or a child who has the ability to

overcome adversity may be less vulnerable to the family violence. A second protective factor is support within the family system, such as a close relationship with one parent, or a close bond with a sibling. A third factor is support external to the family system, such as support from a teacher or close relationships with peers, or competence in academics or on a sports team (Jaffe et al., 1990; Wolak & Finkelhor, 1998). Another important factor that appears to be important for resiliency in children is a supportive, healthy, and resilient mother. In a study completed by Hughes et al. (2001) it was found that mothers who were less depressed, less anxious, and who were able to continue to parent despite the violence that they experienced, had children who exhibited less internalizing and externalizing problems.

The concepts of a developmental psychopathology framework described above were used throughout this practicum to investigate the impacts of family violence on children. In addition to this framework, three theoretical orientations were used to understand the effects of domestic violence on children, and the theories speak to the risk factors that impact children as described in the developmental psychopathology framework. These theories include social learning theory, attachment theory, and trauma theory. Important to note is that the following theories are not mutually exclusive, and may be used together in an overlapping fashion in order to explain the impacts of domestic violence on children (Graham-Bermann, 1998).

Theoretical Explanations for the Effects of Witnessing Domestic Violence

Social Learning Theory

Social learning theory, as described by Bandura (1977), provides a "theoretical framework for analyzing human thought and behavior"(p. vi). Also, social learning

theory is a widely documented explanation for some of the behaviors exhibited by children who have witnessed domestic violence (Alexander & Moore, 1991; Foshee, Bauman, & Linder, 1999; Graham-Bermann, 2001; Harris & Dersch, 2001; Kalmus, 1984; MacEwen, 1994; Swinford, Demaris, Cernkovich, & Giordano, 2000). According to the theory, there is a reciprocal interaction between a person's cognition, his or her behaviors, and the environment, which Bandura (1977) calls reciprocal determinism. These three components all interact with and impact upon each other, and contribute to the behaviors that a child exhibits.

According to social learning theory children learn behaviors from their environment, most notably their parents. Children learn behaviors through direct modeling and reinforcement (Bandura, 1977). The family is integral in teaching children all of the fundamental aspects of life, including social roles of family members, and how to handle difficult situations (Gelles, 1999). According to Bandura (1977), children model the actions of their parents, which serve as guidelines for appropriate interactions with others. In families with aggression and domestic violence, a child is at risk of repeating these behaviors in their external interactions with others. Kalmuss (1984) determined that high levels of first-generation family aggression facilitated both "specific modeling", which included modeling of specific types of family aggression, and "generalized modeling", which included modeling family aggression in general. According to the study, both types of modeling increased the likelihood that the child would take on the aggressive characteristics of his or her parents.

Results of early experiments with children have shown that children imitate and subsequently learn the behavior of a model, especially if that behavior results in positive reinforcement (Miller & Dollard, 1941). In addition, children tend to model people who they look up to, such as their parents (Bandura, 1977). In a study by Carroll (1977), it was concluded that transmission of family violence was more likely to occur in same-sex linkages, where the father had the strongest influence on the son, and the mother had the strongest influence on the daughter. MacEwen (1994) also found that identification with an aggressive father predicted later relationship aggression.

In addition to modeling behaviors of parents, children may also model attitudes, and may develop distorted perceptions and internal schemas. According to Bandura (1973) "exposure to modeled aggression can affect not only the observers' actions, but also their attitudes and values" (p. 85). Children may learn to manipulate, to persuade, and to coerce others to have their needs met just as they witness their parents doing in their relationships (Graham-Bermann, 1998). Social and moral rationalizations and justifications of the aggressive behavior made by parents may also contribute to distorted perceptions in the child (Gelles & Cornell, 1985; Herzberger, 1983). For example, the parents may explain to the child that his or her mother gets hit/slapped/punched only when she does something wrong. The child may begin to believe that violence is okay as long as it is completed under certain circumstances.

In addition to modeling as a way that children learn from their environments, reinforcement also contributes to the environmental learning process of children

(Bandura, 1977). According to social learning theory people do not execute everything that they learn, rather they only repeat behavior if it results in a positive and rewarding outcome, avoiding behaviors that result in only negative outcomes (Bandura, 1977). In a violent family improper behaviors may be rewarded, leading to inappropriate actions of the children in their interactions with others.

A child's environment therefore, contributes a great deal to what they learn. Another important component outlined by Bandura (1977) is a person's cognitive capacity. According to Bandura (1977), people are not passive learners, but rather contribute a great deal to the learning process. Important in the theory is the idea that thoughts mediate behaviors, rather than behaviors occurring without the inclusion of thoughts. The theory says that people are not powerless to the influences of their environments, but rather they can cognitively filter through the external influences and can control their own thoughts and behaviors (Bandura, 1977). Bandura (1977) describes people having many different characteristics that allow them to filter information and assist their learning including the use of symbols, self-regulatory capacities, and the ability to learn vicariously through the use of observational learning. When behaviors finally emerge, they are a combination of a person's environment and their thought processes, and the reciprocal interaction of all three, as a person's behavior also impacts their environment and their cognitive process as well (Bandura, 1977).

Social learning theory as an explanation for the effects of witnessing domestic violence proposes that there is a reciprocal interaction between a child's environment, his or her thought processes, and his or her behaviors (Bandura, 1977). Children

learn social behaviors and attitudes from their environment/parents through modeling and reinforcement, and cognitive process are used as mediators between environmental stimuli (their witnessing the violence) and response (maladaptive behaviors, attitudes, or thoughts) giving the child control over his or her behavioral responses. Behaviors also impact the child's environment and thought processes. Interventions based on this theory are discussed in a future section.

A secondary concern stemming from social learning theory is that children who exhibit symptoms resulting from living in a violent home may be at risk for transmitting the violence intergenerationally. The transmission of violence from one generation to another has been studied extensively, with variable results. According to this theory, each new generation of children learns how to be violent from their families of origin, and repeats the dysfunctional pattern with their own family as adults (Jaffe et al., 1990; Straus, et al., 1980). Modeling aggressive behavior is passed through the generations, and this accounts for the intergenerational transmission of violence.

According to a study completed by Straus et al. (1980) "Violence in one generation affects and encourages violence in another generation." (p. 4). In their study of the intergenerational transmission of violence, Straus et al. (1980) found support for the theory in the following conclusions. First, they concluded that the more violence children witnessed between their parents, the more violent they were towards their spouse. In addition it was estimated that sons who witnessed their father's violence engaged in wife abuse in later adulthood 10 times more often that boys of non-violent parents. The study also supported the intergenerational

transmission of violence theory by tracing violence across three generations of a family. Other studies have also found support for the transmission of violence from one generation to the next (Alexander and Moore, 1991; Carroll, 1977; Foshee et al., 1999; Johnston, 1988; Kalmuss, 1984; Reitzel-Jaffe and Wolfe, 2001).

Although support is offered for the intergenerational transmission of violence theory, many studies have shown that not all child witnesses of violence will become violent themselves (Alexander and Moore, 1991; MacEwen, 1994; Simons and Lin, 1998; Straus et al., 1980).

Social learning theory explains some risk factors, both direct and indirect, that influence children who are exposed to domestic violence, and contribute to whether or not children will transfer the violence intergenerationally. For example, a child may be directly exposed to the aggressive behavior patterns of his or her parents, and to the emotional and behavioral problems of his or her parents. Indirectly, a child may be impacted by paternal irritability, maternal stress, and disciplinary practices of his or her parents. All of these risk factors may contribute to the development of psychopathology in the child. Protective factors may also be present for the child, which may decrease the chance that he or she will imitate the behaviors of his or her parents.

Attachment Theory

According to attachment theory, children form attachments with their primary caregiver, usually their mother, and this attachment directs their future attachments and interactions with others as they grow into adults (Bowlby, 1980). Both the personality and characteristics of the child and the quality of care provided by the

mother contribute to the attachment that is formed (Svanberg, 1998). When a child feels threatened, he or she will exhibit comfort-seeking behaviors (crying, fussing), which he or she hopes will get a response from his or her mother. If his or her mother responds to his or her behaviors in a positive manner (feeding, holding) he or she will be calmed and will feel more secure. The mother provides a secure base from which a child can feel comfortable to explore his or her environment in a healthy manner. A child whose mother does not respond in a positive comforting manner to his or her comfort-seeking behaviors, may not feel safe to explore his or her environment in a healthy manner. This may lead to separation anxiety, loss and detachment in the child, which may lead to developmental psychopathology (Bowlby, 1980). An unhealthy attachment cannot be directly linked to psychopathology, however it may be seen as a moderating factor (Rutter, 1995). According to Graham-Bermann and Levendosky (1997) children who have witnessed domestic violence have more ambivalent relationships with their mothers.

The effects that domestic violence has on maternal functioning impacts the attachments between mother and child and in turn the healthy adjustment of children. (Levendosky & Graham-Bermann, 1998; Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). For example, research suggests that domestic violence directly affects maternal psychological functioning, in the forms of depression and post-traumatic stress symptoms and indirectly affects parenting and attachment in a negative way (Levendosky & Graham-Bermann, 2001; Levendosky, et al., 2003). Levendosky et al. (2003) found that children's observed behaviors were impacted by domestic violence, in that children of battered women showed "less focused attention, less

positive affect, fewer verbal interactions, and less proximity" (p. 283) in their interactions with their mothers.

Domestic violence has also been shown to be associated with higher levels of parenting stress, which impacts a child's adjustment (Holden & Rirchie, 1991; Levendosky & Graham-Bermann, 1998). Levendosky and Graham-Bermann (1998) found that children whose mothers exhibited high levels of parenting stress showed more internalizing, externalizing, and total behavior problems. Holden and Ritchie (1991) also found that high levels of maternal stress were powerful predictors of behavior problems in children. Trauma symptoms have also been hypothesized as influencing women and seen as mediators through which domestic violence affects parenting (Levendosky & Graham-Bermann, 2000, 2001).

In a study completed by Morrel, Dubowitz, Kerr, and Black (2003), it was found that women who had been victimized exhibited depressive symptoms and took part in harsh parenting practices. These women reported internalizing and externalizing behavior problems with their children. Mother-to-child verbal aggression was also a strong predictor of adjustment problems among children in a study completed by Moore and Pepler (1998).

Therefore, the unhealthy attachment that emerges between mother and child in response to the impacts that domestic violence has on maternal functioning may cause adjustment problems in children. A developmental psychopathology framework outlines parent-child attachment as an important factor in the healthy adjustment of a child. As mentioned in the studies above, risk and protective factors may include maternal depressive symptoms, maternal stress, and trauma symptoms in the mother.

Trauma Theory

Trauma theory proposes that children are traumatized by the violence they witness to the degree that they qualify for a post-traumatic stress disorder (PTSD) diagnosis similar to that outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2000). Symptoms children experience therefore are a result of the PTSD effects and may include but are not limited to the following: (a) intrusive re-experiencing of the trauma, which may include the occurrence of dreams or nightmares and intrusive memories; (b) the avoidance of certain stimuli, such as avoiding certain activities reminiscent of the trauma and being less interested in playing or talking with others since the violent event; (c) the occurrence of new behaviors such as sleep problems, irritability, difficulty in concentration, hypervigilance, and an exaggerated startle response and; (d) increased arousal including increased irritability, moodiness and temper tantrums, decreased ability to concentrate, and increased aggressiveness since the violent event (Graham-Bermann & Levendosy, 1998; Levendosky, Huth-Bocks, Semel, & Shapiro, 2002).

Studies have shown that children who witness domestic violence experience traumatic symptomology as described above (Graham-Bermann & Levendosky, 1998; Kilpatrick, & Williams, 1997; Lehmann, 1997; Levendosky et al., 2002; Rossman, 1994;). Graham-Bermann and Levendosky (1998) found that although few children in their study qualified for a full PTSD diagnosis, children exposed to domestic violence experienced PTSD symptoms, including significant levels of internalizing and externalizing symptoms. Levendosky et al. (2002) revealed similar findings in a study of preschool aged children. They found that child witnesses to

domestic violence suffered from traumatic symptomology, however few of the children qualified for the full PTSD diagnosis as outlined by the DSM-IV. They also found the occurrence of externalizing behaviors in preschool children, but only for children who presented with re-experiencing symptoms of the traumatic experience.

Kilpatrick and Williams (1997) found a significant and strong association between witnessing violence and PTSD symptomology in children, and they presented the incidence of PTSD as an explanation for the behavioral, adjustment and emotional problems presented by child witnesses. Rossman (1994) found that children who witnessed domestic violence experienced trauma symptoms at significantly higher levels than did non-witnesses. In a study by Lehmann (1997), 56% of the sample of children met the PTSD criteria as outlined in their study. This group of children reported significantly higher levels of self-reported anger, dissociation, depression, and assault anxiety than the group that did not qualify for a PTSD diagnosis (Lehmann, 1997).

Therefore, according to trauma theory the symptoms that children experience and exhibit occur because they have been traumatized by the violence they have witnessed and they are exhibiting PTSD symptoms. A child is at risk of psychopathology then as a result of the trauma they experienced from witnessing domestic violence. Many protective factors may be in place however to protect a child from becoming vulnerable. For example, in a study by Levendosky et al. (2002) preschool aged children were less likely to exhibit behavioral symptoms in response to the trauma they experienced, but instead exhibited non-behavioral symptoms such as symptoms of reexperiencing the trauma and hyperarousal.

Therefore, the age of a child may provide a protective mechanism as their development would be less disrupted with the absence of behavioral symptoms (Levendosky et al., 2002).

With the help of these explanatory theories, suitable interventions for children may be developed, as these theories will guide the intervention appropriately. It has been noted in the literature that group interventions for children and group interventions in general are lacking a theoretical framework (Bernstein, 1973; Graham-Bermann, 2001; Malekoff, 1997). Basing an intervention in a particular theory helps to guide the intervention and contributes to an enhanced evaluation of the group, as there is a more solid basis from which to evaluate (Graham-Bermann, 2001; Malekoff, 1997). According to Bernstein (1973) "Without good theory, the diagnosis and intervention by group workers tend to be hit or miss" (p. v.). Therefore basing an intervention on theory will not only help to guide the content of the group but will make the evaluation of the group more sound. What follows is an overview of the group work model that has emerged for children exposed to family violence, including the content of group sessions.

Group Work Model for Children Exposed to Domestic Violence

In the late1970's and1980's, the idea that children were affected by the violence that occurred between their parents was just beginning to emerge (Jaffe, et al., 1990). From the symptoms that shelter workers were seeing in children, researchers such as Alessi and Hearn (1984) and Jaffe et al. (1986) began to develop group intervention programs that dealt with the impacts of witnessing domestic violence on children. The group intervention outline that has emerged and is most commonly used today

includes topics that are applied directly to the effects that children typically experience. To follow is the group work model that has evolved for children exposed to domestic violence including session topics that are usually incorporated in group therapy for children.

The Identification and Expression of Feelings

The identification and expression of feelings has been outlined as important in an intervention for children exposed to family violence (Alessi, & Hearn, 1984; Grusznski, Brink, & Edleson, 1988; Wilson, Cameron, Jaffe, & Wolfe, 1989). This task provides children with tools that they can use to express themselves in appropriate ways, and helps them to feel more comfortable in the group as they are able to contribute feelings and opinions (Wilson, et al., 1989). Also important is to teach children when it is and is not safe to express feelings, as their home environment may not be a safe place for the open expression of feelings (Grusznski et al., 1988). Making a collage on feelings, brainstorming feelings, or using feeling cards describing scenarios that evoke different feelings are all techniques that have been described to help children understand and describe their own feelings (Wilson, Cameron, Jaffe, & Wolfe, 1986).

Dealing with Anger and Rage and Appropriate Means of Behaving

Many child witnesses of domestic violence deal with feelings of anger, both internally and externally (Wolak & Finkelhor, 1998). Since many children from violent homes have not seen anger expressed in positive ways, they may have a problem with "healthy" anger (Jaffe et al., 1990). Therefore, teaching children how to express anger in nonviolent and non-abusive ways has been outlined as important

for the group (Grusznski et al., 1988). This may be accomplished by helping the children understand both healthy and unhealthy ways of dealing with anger, through brainstorming and scenarios (Wilson, Cameron, Jaffe, & Wolfe, 1989). Leaders can teach children that it is okay to be angry and to express it, as long as they do not hurt themselves or others in the process (Peled & Davis, 1995).

Other psychoeducational methods may be used to educate the children about the angry feelings they are having. During role plays and discussions for example, children may be asked to look for or think of physical signs within their bodies that indicate that they are angry (Peled & Davis, 1995). Knowing the physical cues of anger may help the child to stop the anger before it escalates into inappropriate behavior. Relaxation techniques may be used as a way of alleviating those physiological symptoms (Wilson et al., 1989).

Teaching assertive behavior is another alternative that may be taught to children who express anger in aggressive and violent ways (Peled & Edleson, 1995). According to Peled and Edleson (1995) being assertive means expressing your feelings to people who are making you angry and standing up for yourself verbally, as opposed to responding physically. Resolving their problems with assertive behavior helps to show them that they can be strong without being aggressive. Providing children with various strategies to deal with their anger gives them alternatives to the violent ones they have witnessed in their homes. Assertiveness may be modeled and encouraged by the group leaders, and may be taught through the reading of stories, or role-playing exercises.

Breaking the Secret

One focus of sessions is breaking the secret of domestic violence (Peled & Davis, 1995). This session topic is important as "Violent families are often socially isolated and their violence is a 'family secret'" (Wilson, et al., 1989, p. 181). Often, children who live in a violent family are very secretive about their family situation and often deny what is going on (Jaffe et al., 1990). They feel embarrassed and ashamed, and often have low self-esteem as a result (Grusznski, Brink, & Edleson, 1988). Once experiences are shared within the group, children see that they are not alone, and that other children are going through the same things they are.

Self-Esteem and Self-Worth

Children who live in a home where physical abuse occurs frequently are often at risk of repeated criticism and unrealistic expectations (Grusznski et al., 1988). This environment of fear and criticism may create low self-esteem in children. Also, children of battered women are often disempowered as a result of witnessing verbal and physical abuse towards their mother (Peled & Davis, 1995), which may contribute to low self-worth. Therefore, incorporating this issue has been described as being beneficial in a group setting (Grusznski et al, 1988; Peled & Edleson, 1995; Wilson et al., 1989).

Self-Blame and Feelings of Responsibility for Violence in the Family

Many child witnesses believe that they are to blame for the abuse that has happened in their family (Grusznski et al., 1988; Wilson et al., 1989). According to Grusznski et al. (1988) this may come to be if family arguments are about child discipline or over the child's behavior, or if the child was told directly that the abuse

was his or her fault. Jouriles, Spiller, Stephens, McDonald, and Swank (2000) found that children who blamed themselves for the violence in their families, had higher levels of externalizing problems as reported by their mothers, and had self-reported higher levels of anxiety and depression. Within the group, challenging beliefs of self-blame may be accomplished through education (Grusznski et al., 1988). Children are told clearly and directly that violence is not their fault, and explanations are provided so the children can understand that they are not to blame for the abuse that occurred between their parents (Wilson et al., 1989). Responsibility for the violence should be placed on the person who is perpetrating the violence. Accurately placing the blame may be done by reviewing step by step chains of events pointing out the behaviors for which the child was responsible, and those for which they were not responsible (Grusznski et al., 1988).

Debunking myths is another way to help the child to understand where the blame for family violence lies (Wilson et al., 1986). This psychoeducational component informs the children about the truths of family violence, thereby decreasing the blame that they put on themselves.

Gender Role Issues

Within the context of an abusive family, children are taught unhealthy messages about the roles that men and women play within a relationship (Grusznski et al., 1988). They are taught that men are powerful, and women are weak and defenseless. They learn that the use of physical violence is successful in achieving desired results. In order to counter these beliefs, it has been suggested that gender role stereotypes be

challenged in the group, and a positive message about women and egalitarian relationships be conveyed (Grusznski et al., 1988).

Personal Safety Skills and Safety Planning

Protection planning equips children with some practical and realistic skills to be used in cases of emergency. Normally parents are responsible for the safety and well being of children, but in the case of family violence parents are not in a position to provide safety to their children (Peled & Davis, 1995). Therefore, it is up to the child to know how to be safe when there is a dangerous situation in his or her home (Peled & Edleson, 1995). It is important to note however, that children should not be given the idea that they are solely accountable for themselves and their safety. According to Peled and Davis (1995), teaching children to take control of their own safety should be a tool of empowerment for them, not a task of responsibility. According to Grusznski et al., (1988) one way to encourage empowerment in children is to use the term "power planning" when discussing protection planning with them. Power planning within the group may give the children a sense of empowerment, rather than feelings of accountability that may come from protection planning. Therefore, children should be encouraged to take control of their own safety when necessary, but should also be made aware that their parents are ultimately responsible for their protection and security.

Children of battered women are also at risk of becoming victims to violence themselves (Grusznski et al., 1988; Jaffe et al., 1990). According to a study completed by Straus et al. (1980) parents who were violent towards each other were more likely to abuse their children then were parents who were non-violent.

Protection planning may decrease the occurrence of child abuse. Protection planning may involve the creation of a protection plan card that lists safe places to go to or to hide in case of danger or when the child feels threatened. Names and phone numbers of trusted relatives, friends, teachers, or neighbors who live close to them are included on the card. Role plays of telephone calls to police or other family members, and rehearsals of what to say when telephoning someone may also be included in the protection planning sessions (Grusznski et al., 1988).

Additional topics that may be covered in group sessions include coping with wishes about the family and dealing with repeated separations or uncertainty about future plans, identifying and using social supports, dealing with issues of divorce and separation, and coping with new parental relationships (Wilson et al., 1989).

What follows is the rationale for using group work as an intervention with children exposed to domestic violence, and consideration of all of the components involved in the group work process with children.

Group Work as an Intervention with Children Exposed to Domestic Violence: Rationale

Working in a group setting is a popular intervention for children of battered women (Jaffe, Wilson, & Wolfe, 1988; O'Keefe & Lebovics, 1998; Rosenberg & Rossman, 1990; Schaefer, Johnson, & Wherry, 1982). There are many reasons for the popularity of this treatment modality:

A Comfortable Atmosphere

The group setting is one that children are used to and comfortable with. Latency-aged children specifically spend most of their time in group settings, such as in school

and in extracurricular activities. Therefore therapy in the form of a group recreates a comfortable and familiar atmosphere for children (Glass & Thompson, 2000).

Acquisition of Social Skills and Knowledge

The group provides the children, through relationships with the other group members, a myriad of social experiences and the opportunity to learn social skills (Northen & Kurland, 2001). These opportunities are absent in individual counseling. According to Schaefer et al. (1982) becoming a social being is a primary developmental task for children. Many children who are referred to group treatment as a result of witnessing domestic violence lack this social ability (Fantuzzo et al., 1991, Wolfe et al., 1986). Group treatment therefore helps children to develop these essential skills. In the group setting for example children may learn how to make friends, how to let other children know that they like them, how to join a group, and how to defend themselves without fighting (Northen & Kurland, 2001). In addition to the opportunity to learn skills, the group provides the children with the opportunity to gain knowledge, through psychoeducation, about their experience with family violence in a safe and empathetic environment (Northen & Kurland, 2001).

Social Interaction

Providing the opportunity for social interaction is important for children because reinforcement from peers is far more powerful than reinforcement from an adult (Coolidge & Frank, 1984, Glass & Thompson, 2000). According to Webb (1996), group intervention fulfills an "intrinsic need" that children have for belonging and acceptance from peers. Slavson (1986) refers to this desire to be accepted as "social hunger". According to Slavson (1986) children between the ages of seven and twelve

have an instinctive need to associate and play with other children as a means of acceptance and belonging. The group therefore provides the setting for children to fulfill their intrinsic need for acceptance and belonging, which is vital for their healthy development.

According to Coolidge and Frank (1984) children taking part in group therapy may be more inclined to change some of their regressive behaviors in order to bond more closely to the group. In individual therapy the opinion of the therapist may not be as meaningful.

Peer Support

Group members may also provide support to one another as they experience therapy together. They may feel less threatened by the therapist and the subject matter when they are not alone (Slavson, 1986). According to Ginott (1961), "The presence of several children seems to facilitate the establishment of a desired relationship between the therapist and each child" (p. 2). Ginott (1961) notes that it is less threatening for a child to enter a group therapy session initially compared to entering an individual session initially because they have peers with them, and they do not have to face the new and strange experience alone.

Peer Influence

Another reason why group work is a widely accepted method of intervention is because of the influence that children within the group have on each other. Throughout group discussions, children see their own experiences in the stories of others, and learn important lessons. Children may reveal more information about their experiences as others in the group begin to reveal their stories. Also, children's

feelings of isolation and stigmatization may be replaced with feelings of hope and belonging when they discover that there are other children who have been through similar experiences (Webb, 1996).

Breaking the Secret

Related to this last point, the group serves as an important setting for addressing the issue of breaking the secret of family violence (Peled & Davis, 1995; Wilson et al., 1986). Children are usually under the impression that they must keep the violence a secret. Keeping a secret may put a lot of stress on the child and he or she may develop some dysfunctional coping mechanisms. By entering a group for treatment, children are given permission to break the family secret, and the opportunity to discuss this issue with other children. This may relieve a lot of stress and pressure that the child may feel.

Economical

Lastly, a practical reason for the use of groups in treatment is the fact that they are economical and resource efficient. In the current state of fiscal restraint and cutbacks the option to treat more than one child at a time seems most practical (Glass & Thompson, 2000). Important to note however is that a group should not be formed for this reason alone, but should be formed when a group is the preferred modality for the population in question (Northen & Kurland, 2001).

Group Work with Children

Regardless of the focus of the group or the population of children targeted, when developing a group treatment program for children there are many factors to consider. Some considerations include group composition, group size, the duration, frequency

and length of the group, and the group setting (Fatout, 1996; Rose, 1998; Rose & Edleson, 1987). To follow is a brief consideration of all of these factors.

Group Composition

Group composition should be considered very carefully when developing a group. Age and developmental level of the children, gender, presenting issues, the extent of problems, background, and racial composition are all factors that may impact the dynamics of the group, and therefore its success (Fatout, 1996; Rose & Edleson, 1987; Schnitzer de Neuhaus, 1985).

Age and developmental level. According to Fatout (1996), age, or developmental level, "...is most crucial in developing groups for children" (p. 44). Research has suggested that groups be comprised of children who are around the same age (Rose & Edleson, 1987). According to Rose and Edleson (1987) this eliminates the tendency of older children to dominate younger children within the group. In addition, children who are close in age generally share similarities in physical, cognitive, and social-emotional developmental levels which may help the members feel more comfortable in the group setting (Rose, 1998). According to Fatout (1996), while taking into consideration the developmental level of the child, a two-year age difference is an appropriate range for membership in a children's group. Schnitzer de Neuhaus (1985) believes that the social and emotional development of the child is more important when selecting group members than the chronological age of the child.

Gender. Mixed results have emerged regarding the gender ratio within children's groups. According to Fatout (1996), mixed groups may not work as well as same gender groups because of the great differences in interests between boys and girls. In

addition, sensitive issues may be more easily addressed, handled, and understood within a same-sex group (Rose, 1998; Rose & Edleson, 1987). Rose and Edleson (1987) point out that groups of latency aged children often divide themselves into separate subgroups of boys and girls, making it difficult to address issues to the group as a whole. According to Northen (1969) consideration of gender in group composition is important, and a mixed-sex group or a same-sex group may both be beneficial depending on the purpose of the group. Northen points out that there are "sex-linked values and norms of behavior...that are important to the development of identity..." (p. 96). Depending on the circumstances of those in the group, either a same-sex or a mixed-sex group may be more beneficial. For example, children who have witnessed maladaptive interactions between men and women as a result of living in an environment of domestic violence, may benefit from the inclusion of the opposite sex in a group setting so they may learn new more appropriate ways of interaction. With respect to latency aged children and those in early adolescence, Schnitzer de Neuhaus (1985) believes that mixed-gender groups may be successful.

Balancing. With respect to the presenting issues and the levels of problems of the children in the group, it is important that each child can relate with someone else in the group regarding his or her particular problem. According to Rose and Edleson (1987), heterogeneity in behavioral attributes within the group is acceptable "provided that each child has a neighbor in the group along each behavioral continuum" (p. 48). Actually it has been suggested that heterogeneity is important for a group to run effectively (Schaefer, Johnson, & Wherry, 1982). For example, a group should be balanced in terms of active and passive, and verbal and nonverbal

children. If too many nonverbal children are placed in a group, little progress would be made; balancing the group with some verbal children would be beneficial. According to Rose (1998) children within the group should have cohorts who have similar backgrounds and cultural roots. If a child in the group is the only one with a particular characteristic he or she may feel different from the others and may feel like he or she does not belong (Northen & Kurland, 2001). According to Schnitzer de Neuhaus (1985) balancing the group by including children who share common characteristics such as presenting problems or minority status, encourages growth of the group.

Group Size

Size is another important component when setting up a group. Between three to eight members has been suggested as appropriate for children's groups (Fatout, 1996; Rose & Edleson, 1987; Schnitzer de Neuhaus, 1985). When there are too few members, the group loses its effect, which may change the impact that it has on members. According to Northen and Kurland (2001), when a group is small, adequate stimulation between the group members may not be achieved. Therefore one of the benefits of group, the influence that members have on each other, may be compromised. If there are too many children in the group, sensitive issues may be difficult to broach, and giving individual attention to each child may be a difficult task for group leaders. Also in larger groups, more communication tends to be directed toward the facilitator rather than toward other group members (Northen & Kurland, 2001).

When the group consists of children who have greater needs, such as children who are highly aggressive or hyperactive, the size of the group should be decreased to accommodate to the needs of these children (Schnitzer de Neuhaus, 1985). Additional factors such as the age of the children may also impact the size of the group (Northen & Kurland, 2001). For example, children who are of late latency age have a great bond with peers (Fatout, 1996), which may encourage a larger group of eight members as opposed to a smaller group of only three. However younger children become confused and overstimulated in large groups, and may benefit from a smaller group (Northen & Kurland, 2001). In addition, when creating the size of a group, attrition must be considered. If your goal is to have a group of seven children, starting the group with nine children may be a good idea, as not all children attend every session, and some may drop out before the end of treatment (Northen & Kurland, 2001; Schaefer et al., 1982).

Duration, Frequency, and Length of Treatment

The duration, frequency, and length of treatment depend on the nature of the group and its composition (Rose & Edleson, 1987). The developmental stage of the children in the group should be considered (Fatout, 1996) as well as their age and severity of presenting problems (Northen & Kurland, 2001). This is important to guarantee that the group is appropriate for those in attendance, ensuring that they receive maximum benefits of treatment. With respect to length, the more discussion oriented the group, the shorter in length it should be, as children can only tolerate a small amount of verbal interaction. A group that incorporates activity and play in addition to discussions can last longer than one that is based solely on discussions

(Schnitzer de Neuhaus, 1985). According to Northen and Kurland (2001) a typical group is about an hour and a half, which gives enough time for an opening, a work period including activities and games, and a closing period.

With respect to the duration of the group, or how many sessions the group will be, short-term groups have become of more focus recently (Fatout, 1996) with between ten to sixteen sessions suggested as sufficient (Rose & Edleson, 1987). However, there should be flexibility in the duration of the group, cutting some sessions out if it seems appropriate, or extending the sessions when more work must be accomplished (Fatout, 1996). Similarly, the frequency and length of the group may be changed from week to week, beginning with many short sessions initially, and fewer longer sessions when the children are more comfortable with each other and the group setting (Fatout, 1996). According to Northen (1969) this holds true for certain populations such as aggressive children who may only be able to tolerate a half an hour initially, but will gradually be able to participate for longer periods.

With respect to frequency of meetings, once a week is the most common format, however it depends on the population (Northen & Kurland, 2001). Another important factor to consider when scheduling a group is the block of time during which sessions are scheduled. Sessions should not coincide with breaks such as summer vacation or Christmas holiday as this may disrupt the fluidity of the group (Fatout, 1996; Rose & Edleson, 1987).

Group Setting

The setting for group treatment should be in a room that is large enough to meet the needs of the children and adequate for any games and activities to be introduced

to the group (Schnitzer de Neuhaus, 1985). The group setting should be a place where children feel safe and comfortable to share their feelings, should be appropriate for intimate circle discussions as well as activities and games, and should be free of any distractions that may take away from the purpose of the group. A room with many distractions for example may turn the facilitator into a disciplinarian taking away from his or her responsibilities as group leader (Northen & Kurland, 2001). According to Northen (1969) the group setting impacts the group's development, the formation of relationships within the group, and group cohesiveness, therefore much consideration should go into creating an atmosphere that is appropriate for the population of the group.

Developmental Phases of Group Treatment

There are a variety of different models of group development (e.g., Brandler & Roman, 1991; Garland, Jones, & Kolodny, 1973; Northen, 1969; Toseland & Rivas, 2001). This practicum will focus on a developmental model created for children and adolescents, which emphasizes the importance of relationships in the therapeutic process (Siepker & Kandaras, 1985). Six authors have contributed to this developmental model (Herndon, 1985; Kandaras, 1985; Lampel, 1985; Lewis, 1985; Schnitzer de Neuhaus, 1985; Siepker, 1985). It is believed that each child progresses through stages of the group similar to the way they advance through the developmental stages in their lives. In order to move onto the next stage in the group or in life, successful completion of the previous stage must occur. Passage through the stages of the group depends upon the actions of the therapist, the relationships and

dynamics of the children, and the group's balance collectively. Groups are vulnerable to stresses and not all groups will pass through all of the stages outlined.

The identification of developmental stages in a group enhances the facilitator's ability to assess both individual and group functioning, and to make decisions regarding content and intervention (Northen & Kurland, 2001). For example, the facilitator may be better able to anticipate certain behaviors and be ready with the appropriate response, when he or she is aware of the dynamics of each developmental stage (Garland et al., 1973). In addition, the facilitator may be more aware of which behaviors are normal during a particular stage, and which are inappropriate and therefore must be addressed. To follow is an outline of the six stages of group development that were used as a guide in this practicum.

Stage I: Preparation

As outlined by Schnitzer de Neuhaus (1985) preparation of the group begins with the first thought of the group and ends with the beginning of the first session. The preparation stage is described as occurring at three levels; at the level of the agency, the level of the clients, and the level of the therapist. First, the agency must consider the inclusion of a group with its repertoire of interventions and mandate, and decide whether it fits with the agency's theoretical orientation (Northen, 1969). Once these initial details are resolved, the agency must prepare for the inclusion of a group in its outline by providing a supportive environment that is conducive to the needs of a group, hiring and training staff, and arranging the administrative details.

The second level of preparation includes the families who will be participating in the group. First, children for the group must be chosen, which according to Schnitzer

de Neuhaus (1985) is a difficult task. Making the wrong decision could mean leaving out a child who should have been included or including a child who is inappropriate. The children chosen for the group are those who are ready to work on their problems and on the common group goals, and who fit according to the balancing of the group (Schnitzer de Neuhaus, 1985). In addition, Schnitzer de Neuhaus (1985) suggests investigating the parents' motivation for wanting therapy for their child, and whether they have healthy or unhealthy motivations. Unhealthy motivations may create problems for the child and may sabotage their child's success in therapy. Healthy parents are those who will allow their children to engage in the treatment process (Schnitzer de Neuhaus, 1985). Once parents and children are chosen for the group, the facilitator must prepare them.

Preparing the parents for the group includes involving them in the treatment process (Schnitzer de Neuhaus, 1985). According to Schnitzer de Neuhaus (1985) "Parents at this stage [preparation] are equally as important as the children" (p. 64). If parents are involved and supported throughout this process, the likelihood that their children will be successful in the group will increase. Children should also be prepared for the group in a way that eases their anxiety. A screening interview including both the children and their parents provides this opportunity, where they can become familiar with the agency, the therapist, and the purpose of the group (Northen, 1969). During this stage of the group when working with this population of children, breaking the secret of family violence is important to ensure a successful outcome for the children in therapy. Breaking the secret occurs when the parent and the child meet with the therapist, and the child discusses some of the fighting he or

she has seen or heard with both the therapist and his or her parent (Peled & Edleson, 1995). By doing this the child gets the message that his or her parent is okay with this disclosure, and that it is okay for him or her to talk about it in the group sessions. Without this permission, the child may feel reluctant to discuss a topic that until now had been a secret.

The third level of preparation involves the therapist who has been designated to run the group. The therapist is responsible for interviewing all of the prospective group members and assessing their suitability for group. During the assessment, information is collected and contributing factors are gathered so that the therapist may help to facilitate change (Northen, 1969). Once group members are chosen, the therapist must consider many factors such as group composition and group size as mentioned above, in order to ensure a successful group. When developing the content of a group, a therapist should begin with careful thought and much advanced preparation with regard to the special circumstances of the population of focus (Fatout, 1996). Taking a proactive stance will help to ensure that the group runs as smoothly as possible and that the members receive the maximum benefit from attending sessions, which is meeting all of their intended objectives.

Once all three levels (including the agency, the clients, and the therapist) have gone through their respective preparations, the group may begin. The beginning of the group is signified by exploration by the group members as they are familiarizing themselves with their new experience.

Stage II: Exploration

According to Lampel (1985) the exploration stage of group development "begins with the first session and ends as individuals in the group have invested enough in the group to personalize and label it as 'my group'" (p. 91). This stage could last between one to three sessions out of a twelve-session group. During this stage of group the children are introduced to the topic of the group and what is expected of them throughout the course of treatment (Rose, 1998). The purpose of the group should be clearly outlined for the children in order for the group to be of optimum benefit to them (Northen, 1969). Identifying the purpose of the group in a candid manner allows group members to become aware of their need for help, encourages a secure environment for sharing of problems and feelings, and eliminates avoidance of the group's topic (Northen, 1969). During this beginning phase of group, the group members discuss less intense issues, and get to know one another (Grusznski et al., 1988), which creates an emotionally supportive safe group atmosphere which is important to the treatment process (Sudermann, Marshall, & Loosely, 2000). More intense issues are tackled once a safe atmosphere has been developed and the children feel comfortable and secure with the group leaders and the other group members.

During this stage children try to find their place in the group. Children acquaint themselves with each other, the group leader, and the environment (Fatout, 1996). According to Northen (1969) it is common for group members to have both positive and negative feelings when they first enter the group. They often feel nervous about being accepted by the other group members (Fatout, 1996). In addition they may have feelings of excitement, anticipation, uncertainty, distrust, tension, and anxiety

(Fatout, 1996). They will examine the group members, and will look for positive reinforcements indicating acceptance from them. With this acceptance, children will feel more comfortable within the context of the group, and will be able to move on to future stages in the treatment process. Anxiety levels tend to be high during this stage, and children act out in order to find out where they belong in the structure of the group (Lampel, 1985). It is the job of the therapist to respond to the children's anxieties about where they belong, letting them know that they are all important in their own way. Children's anxieties will begin to diminish when they feel that they are important members of the group (Lampel, 1985).

During this stage the therapist is responsible for setting limits, communicating support, educating, and clarifying (Lampel, 1985). In addition, the therapist should provide a consistent environment where the children feel safe to express private feelings (Brandler & Roman, 1991). In order for children to feel comfortable and to adjust to the group, leaders must form positive trusting relationships with each child individually and with the group as a whole. Within these first few sessions children look for reasons to come back to the group and the therapist provides a supportive environment that the child will want to return to.

As well as orienting themselves with the other group members and the group leader, children will acquaint themselves with their surrounding environment. They may leave the room to see what is next door, or they may open and close drawers to a desk. These behaviors add to the child's comfort with the environment, ensuring that they are in a safe and secure place.

Once children feel comfortable with all of the components of the group, they begin to question many things that go on within the group (Fatout, 1996). For example, they may question the structure of the group, or the authority and power distribution within the group. Fatout (1996) suggests that the group as a whole should work together to solve some of the conflicts they are encountering. With the help of group facilitators, relationships between members are strengthened, and children continue to develop values, goals, and a sense of purpose in the group. When children are ready they may begin to talk about their desire to change by working on their individual goals. The therapist will work to make the individual goals group goals (Lampel, 1985) which will help to create group cohesion and a sense of "we-ness". Depending on the children and their level of difficulty, initiating change and working on goals may take a while to happen. Initially children are defensive and apprehensive and are not ready to start admitting to any problems and to the fact that they need help (Northen, 1969). In order for progress to occur, any information discussed during the first few sessions, for example the purpose of the group and each child's inclusion in the group, may have to be repeated when the children are more ready to hear it.

According to Fatout (1996) in order for children to move on to the next stage "...they must have moved from non-intimate or parallel relationships to a more intimate system of relationships" (p. 12). Group members must be free of conflicts that may disrupt the flow of the group and impede their ultimate success.

During this phase of the group, parents and teachers may begin to see some positive changes in the children who are attending group. These changes may be because the children are containing their conflicts within the therapy group (Lampel,

1985). On the other hand parents may notice that their children's maladaptive behaviors have become heightened since their attendance in the group (Lampel, 1985). This may be because they are dealing with issues that they are not used to, which increases their anxiety levels both within the group and outside the group.

According to Lampel (1985) dropout or absenteeism rates may be high during this stage. This may occur for many reasons. In one case, a child may not be passing through the stage at the same rate as the other children and may continue to have a high anxiety level while the other children are beginning to decrease their anxiety and feel more comfortable in the group. In another case, a child may feel that the other members of the group pick on him or her. Or, if perhaps the child for some reason does not like the therapist, he or she will not be able to have relief of anxiety through this source.

Rules are created during this phase of the group (Lampel, 1985). Rose (1998) suggests including children in the rule making process, thereby increasing their future compliance with those rules. The issue of confidentiality should be discussed early in the group, preferably within the first few sessions (Lampel, 1985). It is important that children feel comfortable to share their thoughts and feelings with the group and know that what they say in the group will stay private.

Stage III: Anxiety

Before group members are able to move beyond the beginning phases of group into the middle phases where a lot of the work is done, they must resolve all of their initial issues surrounding trust and security. In order to move forward, the group must provide a feeling of security for all members (Brandler & Roman, 1991).

In the beginning of the anxiety stage the children's anxiety levels are high, and as a result they continuously challenge the therapist with their behavior (Lewis, 1985). Many children will convert anxiety to activity within the session. For example an anxious child may be unable to sit still or may talk incessantly. According to Lewis (1985) a therapist should deal with this behavior by balancing control and limits, and allowing the children to express their anxieties through activity.

During this stage the therapist is responsible for letting the children know that he or she continues to accept them despite their observed behaviors. The therapist must be sure to accurately understand the meaning of the words or actions of the children, and must be sensitive to their underlying feelings and concerns (Northen, 1969). In order to successfully progress through this stage, the therapist should use the individual relationships that he or she has established with the children to encourage the formation of relationships between the children, to enhance group cohesion, and ultimately to assure group progress (Lewis, 1985).

As the group progresses through the various stages of group development, children may begin to take on certain roles in the group. Some roles including the scapegoat, the isolate, the aggressor, and the clown, may be disruptive to the group (Northen, 1969; Scheafer et al., 1982). In dealing with the emergence of roles, the therapist should encourage the members to try out new ways of communicating with others, or should assist them in recognizing and adjusting their inappropriate patterns of behavior (Northen, 1969). It has been suggested that the therapist confront both the individual and the group and ask why the behavior has emerged and why the group has allowed it to continue (Schaefer et al., 1982).

During this stage, change that is occurring in the children often creates behaviors outside of group that are opposite to their normal patterns of behavior (Lewis, 1985). For example, a very good child may begin to act out at home or at school. The changes that occur in the child ultimately impact the rest of the child's family and bring about a reaction of anxiety from them (Lewis, 1985). Some parents see the change in their child's behavior as positive and progressive, while others see it as negative and regressive. It is important that the therapist support parents during this difficult time regardless of how they are feeling about the group, and help them deal with their anxieties about their child's behavior and how it is affecting their family. The therapist may support the parents by developing rapport and building a trusting relationship with them. Also, educating the parents about the process and progress of the group would be helpful. In addition, therapists may provide the parents with counseling to help them understand the dynamics of their children's behaviors, to ensure that they contribute to their child's progress, and to ensure that the progress made in the children's group extends to their external environment. If a parent does not deal with his or her own anxieties and is unable to progress through this stage successfully, this will decrease the chances that their child will successfully pass through this stage (Lewis, 1985, Northen, 1969).

The anxiety stage comes to an end when the children have built trusting relationships with each other and the therapist. This is accomplished as the group members recognize the common bond that they share with the others that does not exist elsewhere, which has emerged through sharing the activities and games that are

exclusive to their group experience (Northen, 1969). By the end of this stage children take a sense of pride in the group often referring to it as "our group" (Lewis, 1985).

Stage IV: Cohesion

During this stage anxiety is still present, but it is occurring within each child individually and is not a controlling factor for the group (Kandaras, 1985). Each child struggles to talk about his or her personal experiences in the group as he or she is committed to making changes in his or her behavior. Children's anxieties are lessened as they talk about their feelings, and they begin to realize that sharing with the group is helping them. The children have developed feelings and respect for each other and empathize with one another when stories and feelings are shared. During this stage, there is a noticeable decrease in the ambivalence of members toward the worker and each other, and an increase in interdependence among the members (Northen, 1969). The children feel that they may learn from the stories of the others so they listen when others talk. During this stage of group development, children begin to drop their defense mechanisms and behaviors and develop new more acceptable ones (Kandaras, 1985). The group has become a cohesive unit where everyone feels close and they are eager to attend group each week. At this stage in the group process, members attend on a regular basis and are punctual (Northen & Kurland, 2001).

During the cohesion stage group members who have a very strong identification with the group may lose their personal identity and individuality, and may become too dependent on the group (Northen & Kurland, 2001). It is important that all members benefit from the group without the loss of their own identity, and be able to

function independently when the group comes to an end. According to Northen and Kurland (2001) in order to ensure that this occurs, the group should have a shared purpose, group members and facilitators should collaborate, and freedom of expression, openness, and mutual aid should be encouraged. In addition, values and norms of the group should support healthy growth, and conflict should be acknowledged and coped with through appropriate decision making processes.

During this stage the therapist is responsible for guiding the children as they disclose, by questioning them and clarifying for the group. For those children who are not sharing, the therapist should encourage them to contribute to the conversation, or to relate what has been said to their own experiences (Kandaras, 1985). In addition, the therapist should stop any child from exposing too much information to a group before he or she is ready. As the children express their experiences, it is up to the therapist to help the children make the appropriate links between these experiences and their current behaviors and feelings (Kandaras, 1985). It is also important during this phase that the therapist help to create empathy between members of the group (Fatout, 1996). Creating empathy helps to deepen relationships between the members, thereby aiding in the accomplishment of their therapeutic goals.

During this stage, as the group begins to take over for itself and the children feel more comfortable to share and grow, the therapist will have to take a step back from his or her role as leader (Kandaras, 1985). Although the children in the group have a positive relationship with the therapist, during this stage they tend to depend on him or her less, and rely on the other group members more (Brandler & Roman, 1991;

Northen, 1969). Relying on their fellow cohorts has two advantages: First of all, when group members are able to contribute to help another member, they gain a sense of empowerment. Second, the group member getting the support from the others feels that it is genuine coming from another person who has had similar experiences (Brandler & Roman, 1991).

Stage V: Termination

The termination phase of group treatment involves working on the "...separation and evaluation of the group experience and the progress of each member" (Fatout, 1996, p. 14). The therapist should look at the progress of the group and its members, and decide whether or not they are ready for termination. When making this decision, the therapist should keep in mind that it is unrealistic to continue with therapy until the clients have reached their full potential. Instead, when evaluating their progress they should question whether or not there has been sufficient progress where the members will be able to maintain and/or improve their progress outside of the group (Northen, 1969). If this is not the case and a group with a predetermined duration is coming to an end, follow-up services may be offered to the client. Depending on the goals of the children, their degree of problems, and the available resources in the community, the therapist's evaluation will result in an appropriate recommendation to be discussed with the parents and the children together (Herndon, 1985).

According to Herndon (1985) shortly after the children are reminded of the end of group they begin to regress both individually and as a group. Children display separation and coping reactions including denial, anger, regression, hostility, acting out, grief, relief, joy, and pride (Herndon, 1985). When the group is coming to an end

members often have feelings of ambivalence, and they are sad because of the imminent separation from their close group of friends, but they may also feel gratification for the progress made during the group. Children may also cope with the group's ending by becoming defensive and moving away from those in the group (Northen, 1969).

This stage is characterized by three phases (Herndon, 1985). Phase one includes an increase in discussions by the children about topics that are happening outside of the group, such as changes that are occurring at home. When this occurs, children have taken what they have learned in group and have applied it to their external environments. At this point the therapist should encourage the children to continue to extend what they have learned to other areas of their lives. With a continued increase in these behaviors, the children become more ready to leave the group (Northen, 1969). Phase two begins with the statement that group will be coming to an end soon and includes the separation and coping reactions mentioned above. According to Herndon (1985) a minimum of three sessions should be allotted for termination in order to allow the children enough time to work through their separation issues. Phase three includes reminiscing and reviewing what has occurred over the course of the group. Throughout the group process each group member has progressed and grown, and this phase of the termination stage allows the children to further solidify their growth.

During this stage the therapist is responsible for assuring the children that even though they only have a few sessions remaining, they still have plenty of time to accomplish what they need to do. When the children begin to regress, the therapist

must remain consistent in his or her focus and concern for the children, and should return to structured activities that may assist in rebuilding group cohesion (Herndon, 1985). Most important during this stage is that the therapist help the children to reminisce about the group, to outline what they have accomplished in the group, and to look forward to the future outside of the group (Herndon, 1985). Leaders should work to decrease the appeal of the group and increase the attractiveness of the external environment (Rose, 1998). This may be accomplished by having the children practice strategies learned in the group in their external environments. In addition, the group facilitator may encourage more leadership from the children in the group as a way to increase their confidence about their abilities to achieve their goals on their own. This may help the transition for the children, and may lessen feelings of abandonment that may occur in the absence of such a transition.

The end of the group is usually characterized by a ceremony of some sort. Inclusion of a cake and certificates for children may help them to bring official closure to the group and to move forward. In addition it gives everyone a chance to say goodbye and to have a fun last session.

Stage VI: Closure

This stage begins with the ending of the last session and may last from a few weeks to a number of months (Siepker, 1985). During this stage the children must remove themselves from the intense personal relationships they established in the group in order to allow for separation and growth (Siepker, 1985). Children who experience difficulty terminating may need to see the therapist again for comfort and

understanding. The therapist should be available for the child, and a relationship may need to continue until the child is ready to move on (Siepker, 1985).

During this stage the therapist is responsible for meeting with the families to discuss therapeutic progress made during the group, and to ensure successful transition out of the group. If a child is having trouble separating from the group, the therapist should confront the issue and discuss it with the family, working with them until they can achieve resolution of the problem, and the child can move beyond the group to new endeavors. The therapist completes treatment summaries and evaluates the goals of the group during this time (Seipker, 1985).

Group Work as an Intervention with Children Exposed to Domestic Violence: Empirical Rationale

There have only been a few studies that have evaluated the use of group work with child witnesses of domestic violence, as research in this area is still in its infancy. There have been some positive effects documented, however many methodological limitations impede the conclusion that this intervention is effective.

Jaffe et al. (1986) created and evaluated a group work model and concluded that following group treatment children had increased their strategies for handling emergency situations, had decreased the amount of violence they condoned in their family, and had changed their self-esteem and their attitudes about violence. Methodological limitations of this study included the fact that there was no comparison group and there was a small sample.

Wagar and Rodway (1995) evaluated the same group treatment program developed by Jaffe et al. (1986) with the addition of a control group. When compared

to children in a control group who did not receive group treatment, the children in the group treatment program obtained higher post-test scores on the dependent variables of "attitudes and responses to anger" and "sense of responsibility for parents and the violence". Therefore, it was concluded that the group program had a significant effect on the two dependent variables. More specifically, as a result of inclusion in the group, children were able to adopt more appropriate attitudes and more suitable responses to anger than violence, and children were more able to place the responsibility for the violence on the appropriate person/people. Because all clients were referred by professionals, generalizability of the results were limited.

In a qualitative study, Peled and Edleson (1992) evaluated the Domestic Abuse Project's (DAP) Minneapolis Children's Program. They concluded that the groups influenced children in a variety of intended ways including breaking the secret of violence, learning to protect themselves, having a fun and positive experience, and enhancing self-esteem. Unintended outcomes emerged out of the group experience as well. For example, after children learned that abuse was not okay and it was not their fault, they began to evaluate their parents' behaviors in terms of whether they were being abusive or not. Some parents commented that they felt uncomfortable with these judgements from their children. As another example, the confidentiality rule in the children's group made some parents feel excluded and uncomfortable. By choosing not to share information from the group sessions, children were given power in the mother- child relationship, which created a hierarchical imbalance.

Sudermann et al. (2000) evaluated the London Community Group Treatment Programme for Children Exposed to Woman Abuse and concluded that children

benefited from the group treatment. They found that children changed their attitudes and beliefs about woman abuse, and the causes of woman abuse. In addition the children learned how to keep themselves safe, and became more aware of community resources. This study lacked a control group, and referrals for the group were made by one coordinator, which may have biased the sample of children.

In a study by Pepler, Catallo, and Moore (2000), a peer group counseling program offered by Women's Habitat in Toronto was evaluated. Internalizing behaviors including depression and anxiety, and hyperactive behaviors as reported by mothers, improved after taking part in a group treatment program. Limitations of the study included variability in questionnaire administration, lack of a control group, a small sample, and a lack of follow-up evaluations with the children and their families.

The results of these evaluation studies on the outcomes of group treatment suggest that groups may have some positive effects for children exposed to violence. Most frequently found changes included changes in attitudes about violence, changes in self-esteem and self-perception, and increased strategies for emergency situations. Other positive changes included a decrease in anxiety, depression, the amount of violence condoned, and feelings of responsibility. In addition, group sessions allowed children to break the secret of family violence, to change their beliefs about abuse and their responses to anger, and to have a fun experience. It appears then that group treatment with this population of children has had some beneficial outcomes.

Of the evaluations completed, methodological shortcomings impact the strength of the results. In the evaluations of group work with child witnesses, many have not acquired an adequate sample size, many do not have control groups, and group

participants have been attained mainly from the shelter population of children, which renders an unrepresentative sample. In order to enhance future group interventions, and to benefit children exposed to domestic violence, more evaluations must be done (Peled & Edleson, 1992), and the methodological shortcomings must be accounted for in order for more valid and reliable results to emerge. The inclusion of a control group is important in measuring the extent of change that occurred, larger sample sizes increase the power of the results, and a representative sample is necessary so the results may be generalized to a larger population of children. In addition, inclusion of long-term follow-up should be implemented to see whether change is long lasting, and what factors may be impeding long-term success. To follow is a review of some limitations of group work with child witnesses of domestic violence.

Limitations of Group Work

One main limitation of group work with children exposed to domestic violence is that the population of clients for whom the treatments are beneficial is quite narrow. Considering the heterogeneous nature of this population, with such a wide variety of presenting issues, appropriate and effective treatment within the structured group setting may be difficult to achieve. As an example, groups do not appear to be suitable for children who have more extreme levels of symptoms, especially behavioral symptoms. Results from evaluation studies suggest that group treatment may be more helpful for alleviating mild internalizing behaviors such as attitudes and self-esteem, whereas changes in behaviors and more extreme internalizing problems may not be as significant (Jaffe et al., 1986; Jaffe et al., 1988; Sudermann et al., 2000; Wagar & Rodway, 1995). It has been recommended that group treatment for these

children be accompanied by more intense and long-term individual and family treatments as well as school and community based interventions (Jaffe et al., 1986; Jaffe et al., 1988; Peled & Edleson, 1992; Wagar & Rodway, 1995). In addition, children who have been impacted in more than one way, such as children who have also been sexually or physically abused, may need more than short-term group treatment (Sudermann et al., 2000).

The content of group sessions may be more effective for certain age groups, and less effective for others (Slavson, 1986). In the literature the majority of the groups have been developed for latency-aged children who benefit from the peer group interaction and socialization that the group provides (Slavson, 1986). However, a group setting may be less effective for a group of pre-school children whose needs may not be met in such a setting.

Treatment in a group setting may create some unintended outcomes, as Peled and Edleson (1992) outline in their qualitative study of the Domestic Abuse Project of Minneapolis. For example, as a result of the group's confidentiality rule the children had the choice not to share with their mothers what they had said in the group. This created an unintended boundary between the mother and child, which may have resulted in the loss of an important source of support for the children. These unplanned occurrences limit the effectiveness of the group intervention.

Related to this last point, group work with children is limited because it tends to focus on the individual needs of the child, without consideration of external factors such as family and community that have great impacts on the child. The child may feel better about himself or herself within the context of the group, however constant

putdowns in a violent family may override any progression made in the group. In addition, work accomplished in the group may not have any significance in their lives without the support and understanding of their mothers and other family members, and other community members involved in the child's life such as teachers or school counselors. Group work alone therefore may not be sufficient in that it does not help the child in the context of his or her problems.

Summary

Group work with children who have been exposed to domestic violence has some limitations, and continued research with stronger designs must be undertaken in the area of study to ensure more successful outcomes. That said, group treatment does appear to offer an effective source of help for this population of children. The group provides a context that helps children work through many of their presenting issues. In addition, empirical studies have shown that group treatment helps to change some of the common symptoms that children experience, proving to be more beneficial for children who have mild symptoms. For children who exhibit more extreme symptoms, group treatment may still be an essential component of treatment, but as part of a comprehensive treatment program. This treatment modality therefore appears to be a beneficial service for this population of children. Continued research including empirical studies are needed in order to help the millions of children who are exposed to violence each year, as these studies may reveal improved treatment options for this population.

Chapter III Details of Practicum

Practicum Setting

The practicum was carried out at the Elizabeth Hill Counselling Centre in Winnipeg, Manitoba. The Elizabeth Hill Counselling Centre (EHCC) is a training site for students who are from the Faculty of Social Work and the Department of Psychology at the University of Manitoba. The Centre offers services to families and children. Programs and services available include The Couples Project, which provides services to couples who have experienced violence in their relationship, and The Aboriginal Child Play Therapy Project, which provides a service to children between the ages of five and twelve who have been exposed to domestic violence. The Centre also provides individual and family counselling to those in need, and services to men through the Men's Resource Centre.

Intervention

The intervention included group treatment with children between the ages of seven and eleven years who had been exposed to domestic violence. The goal of the children's group was to educate the children about family violence, to help them understand some of their mixed-up thoughts and feelings and how they may be leading to inappropriate behaviors, and to assist them in developing more appropriate thoughts and behaviors in a safe and supportive environment. The children's groups were influenced by a developmental psychopathology framework, which influenced the assessment and intervention. Important components of this framework included the following: Children are affected by many interrelated factors leading to a heterogeneous population, there are risk and protective factors present for each child

which influence their outcome and their presenting issues, and there are moderating factors that affect the degree to which a child is impacted by family violence. All of these components guided the assessment and intervention. In the assessment we became aware of each child's individual unique experience of the violence they witnessed by questioning both them and their mothers. During this process we were informed about the various factors present for each child, both positive and negative, that might have changed their experience of and response to the violence they witnessed. The information gathered during the assessment was carried over and the intervention was created to be most appropriate for the issues of those children in the group. Three explanatory theories which further illustrated the risk factors that impact children included social learning theory, attachment theory and trauma theory.

Techniques based on the tenets of social learning theory were incorporated into the intervention, revolving around the idea proposed by Bandura (1977) that there is a reciprocal interaction between a person's environment, his or her thought processes, and his or her behaviors, which all contribute to learning. Behavioral techniques such as modeling and reinforcement were incorporated in the treatment process, so as to teach children more positive and healthy behaviors. Also, techniques aimed at altering the children's thought processes were integrated, including psychoeducation of family violence, the introduction of new techniques and strategies, and encouragement of pro-social behaviors. Lastly, the children were given a safe and healthy environment where they could practice appropriate behaviors.

Proponents of attachment theory influenced the intervention by suggesting that children are impacted indirectly, by the effect that domestic violence has on mothers.

Although the main focus of this practicum was not on the maternal component, the positive impact that the mother's group had on the progress of the children warranted discussion of attachment theory and its contribution to the intervention. Discussion of the work accomplished within the mother's group or the work done within the multifamily portion of the one children's group is beyond the scope of this practicum, however it is important to note the positive impact that the mother's group had on the progress of the children.

Trauma theory also influenced the intervention. It has been suggested in research that child witnesses of domestic violence are traumatized by the violence, which is evidenced in their experience of PTSD symptoms (Graham-Bermann & Levandosky, 1998; Kilpatrick & Williams, 1997). Based on this understanding, certain interventions were incorporated into the group setting. Because children who have been traumatized experience emotional and cognitive difficulties, important in the group was to identify and change negative belief patterns through psychoeducation, through the debunking of myths, and by helping the children to understand and express their emotions in healthy ways (Kilpatrick & Williams, 1997). Children who have been traumatized also exhibit externalizing symptoms, therefore helping the children to understand the root of their anger and assisting in controlling their anger was incorporated in the group (Kilpatrick & Williams, 1997). The use of psychoeducation, role plays, and role modeling were some techniques used in this respect. Also important for children who have been traumatized by the violence they witnessed is to help them to realize they are not alone (Kilpatrick & Williams, 1997). The group setting is the best arena for this purpose.

Two groups were run for twelve consecutive weeks, beginning in January 2003 and ending in April 2003, with each group convening once per week. One group included a group therapy component with the children, as well as a multifamily component where the children and their mothers came together for the last portion of the group. This group will be referred to from this point on as the multifamily group. The children's group component was 75 minutes in length. This group was co-facilitated with a student at EHCC completing requirements for a Bachelor of Social Work Degree. A second group consisted of a children's group that was 120 minutes in length. The second group did not include a multifamily component, however, the mothers of these children took part in a support group for women exposed to domestic violence concurrent with the children's group. This group will be called the children's group from this point on. This group was co-facilitated with a child therapist from a local women's shelter.

Topics of the groups included getting to know each other, feelings, different kinds of hurting, feeling angry, fighting in families, breaking the secret, mixed-up feelings, feeling afraid, getting along with others, different kinds of families, and saying goodbye (see Appendix A for a detailed outline of group sessions).

Participants

Children between the ages of seven and eleven years, who had been exposed to domestic violence and who were experiencing behavioral and/or emotional problems as a result, were included in the group therapy sessions. To be eligible for the groups, both the mother and the child had to be voluntary clients and had to be motivated and willing to attend sessions and to work on the child's issues.

Excluded from the groups were families who had substance abuse problems. This was part of the exclusion criteria as parents are an important part of the therapy process. If parents are not fully competent and cognizant of their children's activities, their children will not receive the full benefit of the group. Therefore it was considered important that the parents did not abuse drugs or alcohol.

Also excluded from the groups were families who were still living in a violent environment or who were at risk of future violence. Children still living in a home with violence may not benefit from the opportunities that a group may provide (Sudermann et al., 2000). They may be too scared to reveal information within the group, which may consequently impede the healing process.

Also excluded from the group were children who were in crisis or who had needs that required a more intense intervention than the group was able to provide. The level of issues was assessed on a case by case basis, and was based on the opinions of my supervisor and myself from our knowledge taken from the intake interview and any known history of the child. Research suggests that children who experience more serious problems may not benefit from group treatment (Jaffe et al., 1986; Wagar & Rodway, 1995). In addition, their issues may disrupt the flow of the group and the subsequent progress of other participants.

In cases where parents had joint custody or for whom there was no custody arrangement in place, permission of both parents was legally required in order to proceed with treatment. In order for permission from the mother to be sufficient, she had to have sole custody of the child or joint custody with primary care and control.

It was necessary to be aware of and to comply with legal standards and agency policy around consent.

Children who were in foster care were not eligible for treatment. In order to be eligible, the child had to be living with his or her non-abusive parent. This was important as neither the research nor the treatment implemented in this practicum incorporated any of the factors unique to a child in foster care. Therefore the group treatment program outlined may not have been appropriate. In addition, although not the primary focus of this practicum, the bond between mother and child was a part of the multifamily group. This may have been awkward for a child and his or her foster parent when participating in a group of children with their natural parents.

Recruitment

Children for the multifamily group were recruited from Child and Family Services and various community agencies that provide services to women and children affected by domestic violence. Seven families were recruited for the multifamily group, and a total of three families remained at the completion of group. Of the families who did not complete the group, one attended six sessions and was removed from the group because of the child's aggressive behavior. This child's behavior was deemed disruptive to the group's progress and intimidating to the other group members. In addition, the group did not appear to be the best mode of intervention for the child. Therefore it was decided that this child should be removed from the group for the best interests of everyone. Another family attended two sessions before they removed themselves from group. This was precipitated by circumstances in the family that made attending group at that time difficult. This family expressed a desire

to participate in a future group when the timing was better. Two families did not attend any sessions once they were recruited for the group. Of these two families, one family did not attend initial sessions due to sickness in the family and "having a bad day". Subsequent sessions were missed for unknown reasons as the family did not call to explain their absence and did not return telephone calls regarding their absence. The other family did not attend any sessions once recruited for the group due to safety concerns that emerged suddenly prior to the beginning of the group.

Two families were excluded from the group early in the recruitment process. One family was excluded because they continued to live with the abusive individual and another family was excluded because the father would not consent to the child's inclusion in the group.

Children for the children's group were all children of women who had been to a women's shelter, and who were now receiving follow-up services. This was not a requirement, but a result of the recruitment process. Seven children were recruited for the children's group, and a total of four children remained at the completion of the group. Three families did not complete the group. One family attended three sessions and because of personal reasons and low attendance decided to remove themselves from the group. In another family, the mother attended and completed the mother's group, but her child did not attend any of the children's sessions, as his father would not sign the consent forms to allow him to attend. A third child was deemed unsuitable for the group following the initial assessment. She was a seven-year-old girl who was a sibling to one of the children in the group, and because she was chronologically and developmentally younger than the other group members, and

she was more reserved and quiet compared to the other group members who were more rambunctious, she did not seem suitable for the group. The girl's mother was given the chance to make the final decision, and she decided that her daughter might benefit from inclusion in a different group that would be more tailored to her characteristics. This family was given the opportunity to attend a subsequent multifamily group. The needs of all of the families who were excluded from the group or who dropped out of the group were a primary concern to my supervisors and myself, and families were referred to other services as necessary.

Practicum Committee

The practicum committee included Dr. Diane Hiebert-Murphy who is a Social Work professor at the University of Manitoba and who is also my primary advisor. A second committee member was Linda Perry, MSW who is a Program Manager at the Elizabeth Hill Counselling Centre with extensive experience working with children, and in the area of domestic violence as it pertains to children as witnesses. Linda Perry was my main field supervisor. A third committee member was Sharon Kuropatwa, MA, a Policy Manager with the Family Violence Prevention Program, department of Family Services and Housing, Province of Manitoba.

Supervision

Supervision for the multifamily group took place once a week at the Elizabeth Hill Counselling Centre with me and my field supervisor, Linda Perry, as well as the facilitator and co-facilitator of the women's group, and the co-facilitator of the children's group. Supervision of the children's group took place once a week at the Elizabeth Hill Counselling Centre with myself and my field supervisor, Linda Perry,

as well as the facilitator of the women's group and the co-facilitator of the children's group.

Supervision sessions provided the chance for in-depth debriefing and discussion about the group, as well as a chance for questions to be answered. This time was vital to the learning process as it gave me the chance to reflect on the previous group session, to get a better understanding of the children's behaviors in the group setting, and to get ideas about future sessions. During supervision sessions, I utilized notes that I had documented in a learning journal following each weekly session. These post group notes proved to be helpful in a few ways. First, recording the information directly following the group when the information was fresh in my mind assisted me in remembering small details of the group and cued me during supervision sessions to particular components of the group that were important. In addition, two groups were facilitated each week which made it difficult at times to remember who in which group had done what. Therefore, summarizing notes following each group helped to keep the groups and their contents separate and organized. Also, writing in the journal was helpful in the learning process, as it created an opportunity for an individual debriefing and reflection of what occurred in the group. This at times was more important than group itself, as it enhanced what I took away from the group and in turn impacted what I brought to the group in the next session.

Files were kept for each family in accordance with EHCC policy. Kept within each file were an intake summary, session notes, and a termination report. These were also helpful in the learning process, as they required thoughtful execution.

Assessment

Two meetings occurred with the family prior to the beginning of the group. The first meeting included the mother and the group facilitators without the child. During this meeting background information was obtained from the mother and her feelings about how her child had been impacted by witnessing family violence were discussed. This meeting also allowed the mother a chance to become familiar with the agency and staff, and to ask any questions about the therapeutic group. During this meeting the eligibility criteria were assessed, and the mother filled out the evaluation measures. During the second meeting, the mother and the child met together with the group facilitators and the important task of "breaking the secret" occurred. This step was important in order for the children to make progress in the group (Peled & Edelson, 1995). This was accomplished when the children discussed an incident they remembered seeing between their mother and her abusive partner. Breaking the secret in front of their mothers lets the children know that it is okay for them to talk about their experiences in the group context (Sudermann et al., 2000). Following the breaking of the secret, the child was interviewed alone, and he or she was asked questions about his or her experience with family violence, and was assisted in filling out the evaluation measures. The second interview session also included a discussion about the purpose of the group with both the mother and the child together.

Having an initial assessment with the mother and the child ensured that the family met the criteria for the group treatment intervention. In addition, individual goals for each child were outlined and discussed. With the help of myself and my field

advisor, the mother and child outlined specific goals and objectives that they wished to achieve throughout the course of the group. At the conclusion of the group, these goals and objectives were reviewed to see if they have been achieved and to what extent.

Evaluation of the Clinical Interventions

Evaluation is an important part of practice. According to Bloom, Fischer, and Orme (1999) evaluating practice provides a foundation for any claims to effectiveness. In addition to ensuring the effectiveness of practice, evaluation is also important as a way to build the knowledge base of the social work profession (Kirst-Ashman & Hull, 1999). Also, evaluation is an ethical obligation for social workers, ensuring that clients are given the most effective treatments (Kirst-Ashman & Hull, 1999).

The evaluation helped to assess whether or not each family's goals and objectives were met at the conclusion of the group treatment sessions. Evaluation determined if each child was experiencing more or fewer symptoms. In order to assess whether or not the symptoms of the children in the group had changed, a pre-test/post-test design was used, administering measures prior to the beginning of group during the assessment for the pre-test, and following the twelve weeks of intervention as the post-test. These tests measured concepts that were the focus of the intervention. Concepts that were assessed and measures that were incorporated in the evaluation included the following:

Children's Self-Esteem

Internalizing behaviors including self-esteem, depression, and anxiety are impacted as a result of experiencing family violence (Wolak & Finkelhor, 1998). Children often have low self-esteem, are depressed, and are anxious when they live in a home where there is violence. The group intervention employed here attempted to teach the children to have confidence in themselves by exposing them to a variety of new circumstances. For example, the group provided children with positive role models through the group facilitators, positive interactions through psychoeducational games and activities, and positive affirmations throughout the course of the group. Therefore, the intervention was aimed at improving the children's self-esteem. Administration of a scale to measure self-concept helped to measure the impact of the group on the children's internalizing behaviors.

The Piers-Harris Children's Self-Concept Scale (The Way I Feel About Myself) (Piers, 1984) was used to assess self-concept in children and adolescents. It is designed for children in grades four through twelve, or between the ages of eight to eighteen years, and measures the children's conscious self-perceptions. It was administered to all of the children who made up the two treatment groups before and after the group. The scale consists of 80 statements to which individuals respond yes or no, indicating that the statement does or does not describe the way they feel about themselves. The scale includes six "cluster scales" including behavior, intellectual and school status, physical appearance and attributes, anxiety, popularity, and happiness and satisfaction. The test takes 15 to 20 minutes to complete and can be administered to individuals or to a group. A high score on any of the cluster scales

and a high total score indicates a high self-concept, and low scores indicate a low self-concept (Piers, 1984). Any scores that are in the 16th percentile or below should be considered significant (Piers, 1984).

For the total score on the Piers-Harris, the normative sample consisted of 1,183 children in grades 4 through 12 in a small town in Pennsylvania in the 1960's. Norms for the cluster scales were based on a sample of 485 public school children from the same school system. In 1984, the authors presented a revised manual for the scale. Epstein (1985) points out that "...although norms are several decades old, subsequent research has generally provided continuing support for use of the instrument as it was originally intended" (p. 1169). Test-retest reliabilities range from .42 to .96, and internal consistency ranges from .88 to .93 (Piers, 1984). With respect to validity, there was a modest relationship between the Piers-Harris and other measures of self-concept, with correlations to other measures ranging from .32 to .85 (Piers, 1984). In addition, relationships with the Piers-Harris and other personality and behavioral measures were generally in the direction expected (Piers, 1984). For example, positive self-concept was generally negatively correlated with emotional and behavioral difficulties. In addition, Jeske (1985) notes that "estimates of content, criterion-related, and construct validity from numerous empirical studies have generally been quite acceptable" (p. 1169). Jeske (1985) views the Piers-Harris Children's Self-Concept scale to be "the best children's self-concept measure currently available" (p. 1170).

Child Behavior Problems

Child behavior problems that occur as a result of exposure to domestic violence may be seen as external problems, such as aggression and delinquent behaviors or internal problems, such as anxiety and withdrawal (Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Wolak & Finkelhor, 1998). The intervention employed in this practicum attempted to tackle these issues by exposing the children to a non-violent atmosphere that taught alternatives to aggression, promoted healthy behaviors in the child and by provided psychoeducation, support and empathy. Therefore, the child's behavior problems, both internal and external were expected to change in positive ways as a result of the intervention. Administration of the Child Behavior Checklist for ages 6-18 (CBCL) (Achenbach & Rescorla, 2001) aided in determining whether the 12-week group treatment had any impact on the externalizing and internalizing symptoms displayed by the children.

The CBCL has been used in many studies to measure the behavior problems of child witnesses to domestic violence as it has both externalizing and internalizing disorder scales (Grych et al., 2000; Jouriles et al., 2000; Litrownik, Newton, Hunter, English, & Everson, 2003; McDonald et al., 2000; Ware et al., 2001). The number of studies that utilize this measure speak to its effectiveness in terms of reliability and validity.

The CBCL was designed to provide data on the prevalence of behavioral problems and competencies in children by asking parents questions about their children's behavior (Achenbach & Rescorla, 2001). According to Achenbach (1991) "Parents

(and parent surrogates) are typically among the most important sources of data about children's competencies and problems" (p. 2).

The CBCL is completed in approximately 15-17 minutes and consists of two parts. The first part includes 20 items that ask about the child's social competencies and how they compare to other children their own age, and the second part consists of 118 specific problem items. Parents respond to these 118 questions by answering "0" for not true, "1" for somewhat or sometimes true, and "2" for very true or often true of the behaviors of their children.

Test-retest reliability of the item scores for the CBCL are .95 for behavior problems and 1.0 for social competence. Test-retest reliability for the scale scores are high and range between .80s and .90s (Achenbach & Rescorla, 2001). Inter-interviewer reliability of item scores in the CBCL are .93 for the competence items, and .96 for the specific problem items (Achenbach & Rescorla, 2001).

Content validity was found to be high because clinically referred children were distinguished from their non-referred counterparts by their scores on the CBCL. In addition content validity of the CBCL "has been supported by four decades of research, consultation, feedback, and revision..." (Achenbach & Rescorla, 2001, p. 135). Construct validity is high in that there were significant correlations with measures that were similar to the CBCL, such as Conners Parent Rating Scale, and with DSM criteria (Achenbach & Rescorla, 2001). Criterion-related validity was demonstrated by showing significant differences between demographically matched referred and non-referred children on all profile scores for all age and sex groups (Achenbach & Rescorla, 2001).

According to Furlong and Woods (1998), the CBCL "...is accepted as the premiere instrument of parent-reported emotional and behavioral problems of their children" (p. 224).

Client Satisfaction

Client satisfaction scales were administered as a post-test measure to the children and their mothers. In both groups, the mothers were given a questionnaire regarding their evaluation of the children's group, and the children were given a questionnaire regarding their assessment of the children's group (See Appendixes B and C). These measures assisted me in assessing the success of the group according to the children and their mothers, and the results of the measure contributed to possible suggestions for future groups. In addition to the scales, feedback from the mothers and/or their children throughout the course of the group or in the follow-up interviews was helpful in assessment of the group's success. The outcomes of the client satisfaction scales and verbal feedback assisted in revealing whether or not the goals and objectives of the families were met.

Clinical Observation

My analysis of the group assisted in determining the success of the group as a whole and the progress of each member individually. Analysis was accomplished through the use of a learning journal and information gathered at weekly supervision sessions. This information combined with the other qualitative and quantitative measures assisted in the evaluation of the group intervention.

Chapter IV Analysis of the Group Intervention

Group Member Profiles for the Multifamily Group

Jeremy[2]

Jeremy is a nine-year-old boy. Jeremy's mother Jane left a physically and verbally abusive relationship with Jeremy's father a few years earlier. Jane currently lives with a new partner and her four children, who range in age from one to sixteen years. Jeremy witnessed many verbal arguments between his mother and father, and a few physical fights as well. Jane was concerned about the behaviors that Jeremy was exhibiting. According to Jane, at the time of intake, Jeremy worried a lot, he got angry and frustrated with the children at school, and had occasional outbursts where he would hit the other children. In addition, he did not like to talk about his feelings, he was emotional and sensitive, and he struggled with his schoolwork. Jeremy was diagnosed with anxiety and depression by a psychiatrist, however no medication was prescribed. Jeremy has telephone contact with his dad, and sees him once a year. Jeremy and Jane were referred to EHCC through a school social worker who worked with Jeremy on an individual basis once a week at school. Jeremy attended nine of the ten group sessions.

Brooke

Brooke is a ten-year-old girl whose cultural background is Metis. Brooke's mother Anne was in a physically and verbally abusive relationship with Brooke's father for many years until recently. Anne is a single parent who lives with her five

[2]All names have been changed to protect participants' identities.

children, who range in age from two to ten years. Brooke witnessed much yelling and screaming between her parents and she witnessed some physical abuse and controlling behaviors towards her mother by her father. On one occasion, Brooke got in the middle of a physical altercation between her parents in an attempt to stop them. Brooke's father was at times verbally abusive towards Brooke and her siblings, calling them names and yelling at them. According to Anne, at the time of intake, Brooke was very angry with her and blamed her for the dissolution of the relationship with her father. Anne described feeling frustrated with some of Brooke's behaviors saying that Brooke would pull her hair, kick and punch her, and call her names. In addition, Brooke had a conflictual relationship with some of her siblings, where Brooke would bite and hit them. Brooke has weekly visits with her father. Anne and Brooke were referred to EHCC by a local women's shelter. Brooke attended seven of the ten group sessions.

Rob

Rob is a ten-year-old boy. Rob's mother Juli was in a physically and verbally abusive relationship with Rob's dad for a number of years. The relationship included isolation and control as well. Rob was not to have contact with his father due to a protection order that was put in place over a year ago. However, up to approximately one month prior to intake, Rob's dad breached the order and had contact with Rob on a few occasions. Juli is a forty-year-old single parent living with her three children, who range in age from four to nineteen years. Juli described Rob as controlling and aggressive, said that he has "fits of rage", and he has no respect for women. Rob was diagnosed with Oppositional Defiant Disorder in 2000. Juli was receiving individual

counselling at EHCC and was referred to the group by her counsellor. Rob attended nine of the ten group sessions.

Travis

Travis is a nine-year-old boy. Travis's mother, Marsha was in a physically, verbally, and sexually abusive relationship for a few years. The relationship included isolation and control of Marsha as well. Marsha was extremely depressed during the relationship and was unclear about what Travis witnessed, and whether or not he was abused himself. Travis was in foster care for a period of one year, and was recently returned to his mother's care. Marsha is a thirty-five-year-old single parent who lives with her two children, ages nine and sixteen. At the time of intake, Marsha described Travis as aggressive at home and at school, and said that he had outbursts, and that he did not listen to her. Travis was diagnosed with ADHD, and at the time of intake was taking Ritalin and Respiritol for his aggressive behaviors. Travis attended six of the ten group sessions. Throughout the group, Travis exhibited aggressive behaviors towards the others in the group, and had difficulty controlling his aggressive behaviors. After Travis had two "outbursts" in the group, Travis and Marsha were asked to leave the group and were referred for individual counselling at Elizabeth Hill Counselling Centre.

Jonathan

Jonathan is an eight-year-old boy. Jonathan's mother Karen experienced physical and verbal abuse by her father and by a few of her partners, some of which Jonathan witnessed. During one incident Jonathan witnessed his mother being strangled by one of her partners. According to Karen, at the time of intake, Jonathan expressed his

anger in aggressive and sometimes violent ways, was unable to express his feelings effectively, had no social skills, was disruptive in school, and was stubborn. Karen lives with her partner and her two children, ages four and seven. Karen became aware of the group program at EHCC from a brochure at a local resource centre. Jonathan attended two group sessions, and because of new circumstances, Karen decided that attending group at this time was not appropriate for her and Jonathan.

Analysis of the Group Intervention: Multifamily Group

To follow is an overview of the stages of group development as outlined by Siepker and Kandaras (1985), with an analysis of how the multifamily group passed through the stages.

Stage I: Preparation

The preparation stage begins with the first thought of the group and ends with the first session (Schnitzer de Neuhaus, 1985). As outlined by Schnitzer de Neuhaus (1985), this stage occurs on three levels; at the level of the agency, the level of the clients, and the level of the therapist. At the agency level, EHCC was well equipped to host a group for children exposed to domestic violence, as groups on this topic are facilitated at EHCC twice every year. EHCC was prepared for the implementation of a treatment group on all levels including the provision of a supportive environment, well organized administrative details, and adequate space that was appropriate for the population of children. The children's group took place in a large room in the Men's Resource Centre (MRC), located on the floor below EHCC.

With respect to the clients, following the assessment interviews, there were two families who were deemed unsuitable for group. In one case, the group was not

suitable because the child had visits with his father on the same evening as the group was scheduled to run. This family was referred for individual counseling at EHCC. In the other case, the mother was still in the abusive relationship, which continued to have an impact on her children. One of the requirements of the group was that the children must be in an environment that is free from witnessing any abuse. This mother was given contact information for shelters in her area. Although she was not eligible for the multifamily group, she was referred within EHCC to assess for potential individual therapy for the children.

During the second meeting with the mothers and the children together it was difficult for some of the children to discuss the topic of family violence. Making it even more difficult at times was the reluctance of the mothers to discuss the topic, and their visible emotions surrounding the topic. During the second meeting with Jane and Jeremy for example, Jeremy had a difficult time expressing his feelings initially. He was reluctant to discuss any occurrences of family violence, and he was giggling when asked certain questions. When Jane was asked to help Jeremy remember a violent episode, she became very emotional. This added to Jeremy's confusion and the difficulty of the situation, as he was asking "Why are you crying mom?"

Following the second meeting, the children were given a tour of EHCC and the group therapy room. In addition, I helped the children fill out the pre-test measures. This helped me to get to know the children a bit better, and allowed the children to feel more comfortable with me and with the agency. In all of the cases, the children left EHCC appearing more relaxed than they had when they arrived.

The responsibility of the therapist is the third level of the preparation phase. This first involved researching of the clinical and empirical literature, and developing a framework for the group. I had to decide on appropriate theoretical orientations that would guide the group and would lead to successful outcomes in the group setting. The group was guided by a developmental psychopathology framework, and theoretical orientations that helped to influence the intervention included social learning theory, attachment theory, and trauma theory. Knowledge of the tenets of each theory assisted in the implementation of appropriate intervention techniques, which were based upon these explanatory theories. Preparation also involved recruiting for the group by sending out faxes to community agencies, setting up assessment meetings with all of the families that were referred, and preparing the content of the group sessions.

The recruitment process was a challenging one for many reasons. First, it was difficult to obtain clients who fit all of the criteria for the group. For example, the children in the group had to be between the ages of eight and eleven, they had to be living with their mother, and they had to be out of the violent environment. These were considered necessary ingredients for a successful therapeutic outcome, however recruiting enough children who fit the profile was challenging. Second, it was difficult to begin the group at the predetermined start date, as some families had to reschedule appointments, and some did not attend scheduled appointments at all. Also, of the four families who had completed the assessment interviews and were chosen for the group, two did not attend the first session. As the group was heading into the second week, two more families had been recruited to make a total of six

families recruited for the group, however only one of the families attended the second week. Although it was a challenging process getting the group together, it was up and running by the end of January 2003.

Stage II: Exploration

The group began slowly as the content of the first two sessions had to be deferred due to low attendance. During the first week two families attended and during the second week one family attended. Instead of formally beginning group, Theraplay (Jernberg, 1979) games and snack made up the content of these first two sessions. The group formally began on the third week. As the group began, it was important to implement structure that would be maintained throughout the duration of the group. First, areas in the therapy room were designated including the check-in circle, the craft corner, and the game area. In addition, an agenda was displayed showing the children the content of each session. Each session also began with check-in and ended with check-out. According to Brandler and Roman (1991), a consistent environment allows children to feel safe to express their private feelings. Keeping the environment predictable is also important as many child witnesses are experiencing PTSD symptomology (Levendosky et al., 2002). The children in the group appeared to appreciate the structure, and came to depend upon it. During one of the first few sessions, the agenda was mistakenly left in the supply room and was not displayed when the children came in to begin the session. Within the first thirty seconds, one of the children asked where it was. Also, in each session the children liked to follow the agenda strictly, and if anything was skipped over or missed, they would ask why.

The children were also very intrigued by the other group members, and when there were absences they were very curious about the missing child. At the check-in circle, there were arrows with a child's name on each. At the beginning of each session, the children took the arrows and placed them on the feelings they were having. Questions emerged regarding the arrows of which there were no owners. "How old is he?", "What does she look like?", "Why isn't she here?", "Is he coming next week?", and when one group member stopped attending group, the children were very interested to know why he was no longer coming to group. This may have been important to the children in terms of maintaining the group's structure and keeping the group safe and secure. In the first few meetings the children were introduced to other children who had been through similar experiences. This provided the opportunity to decrease their sense of isolation which according to Kilpatrick and Williams (1997) is important for children who are experiencing PTSD symptoms.

Confidentiality was introduced within the first group session in the form of "Secret Sammy". Secret Sammy was a beanie baby that was a dog, and he lived inside a locked box. Each session, we would open up the box and let Secret Sammy out to hear our stories. At the end of each session, Secret Sammy would go back in his locked box with all of our stories and would not tell anyone. The children were told that they should keep any stories they hear in the group private, just like Secret Sammy. The children were very intrigued with Secret Sammy. Each week, they would always remember to open the box and take him out. During this phase of group development, the children wanted to hold him and throw him around, they would argue who got to hold him, and often would use him as a distraction from the

content of the group. After a few sessions, it was decided that Secret Sammy would stay in his home, but would still be listening to our stories. When this rule was implemented it helped to decrease the distraction, however there were still times when someone would take Sammy out of his box and play with him.

During the first session, the purpose of the group was introduced to the children. They were told that the group was for children who had seen or heard fighting in their families. Although the children were given a chance to discuss their experiences, none of them went into detail. Because the children were getting comfortable with each other and the atmosphere of the group, they were not expected to discuss serious issues. According to Grusznski et al. (1988) it is important that the group members discuss less intense issues initially in order to create an emotionally supportive safe group atmosphere. This sets the stage for them to feel comfortable to share with the others later on in the group process.

During this stage of group development, the children helped to brainstorm group rules. According to Rose (1998), having children help with the rules increases the chance they will follow the rules. The rules were written on a large sheet of paper and were displayed each session. When the rules were referred to due to rule-breaking behavior, many of the children did not argue with the rules they had created themselves, and would abide by the rules when asked. Although there were many times where the children would stop their rule-breaking behavior, there were other times when they would not. As an example, Travis had a difficult time following the group rules, especially the "no hurts" rule. He would often initiate contact with the

others in the group, including nudges, small punches and kicks, and headlocks and other wrestling moves. He had to be reminded many times about the rules.

One technique used with Travis during this stage to deal with some of his aggressive behaviors was a time-out, which followed an incident where he was breaking the "no hurts" rule. During this incident, Travis was asked to remove himself from a game for a time-out, and return to the game when he was able to follow the rules. The purpose of this technique was to teach Travis that his behaviors were inappropriate and were not acceptable in the group. According to social learning theory, Travis may have learned this behavior by witnessing it at home, and he may have felt that it was an appropriate way of behaving in other contexts (Jaffe et al., 1990). By giving Travis a time-out I was attempting to teach Travis more appropriate ways of resolving conflict. Travis left the game quite angry and yelled at the rest of the group for a few seconds. He then sat for a few minutes and watched the game, and then he rejoined the game in good spirits and willing to follow the rules. This technique worked this one time with Travis, but when attempted a second time, it was not successful in stopping his aggressive behaviors.

Another technique used with Travis was reinforcement of positive behaviors. This technique is one that flows from instrumental conditioning where "the behavior of the organism is instrumental in determining whether the reinforcing or punishing event occurs" (Carlson, 1990, p. 107). Reinforcement is an important component of social learning theory, which outlines that people repeat behavior if it results in a positive outcome (Bandura, 1977). Any time Travis was following the rules, and was not initiating physical contact with another child, he was rewarded with a candy. Travis

appeared to like these rewards, however the rewards did not appear to be enough to stop his aggressive behaviors towards the other group members.

During the third session, Travis became engaged in a physical altercation with another child in the group. During this incident, four steps as outlined in Siepker and Kandaras (1985) were used to control Travis's aggressive behavior. First, Travis was addressed verbally, however he did not respond to the verbal comments. Second, he was approached physically (I put a hand on his shoulder). When he was approached in this way his behavior escalated. At this time, Travis was hurting another child, so as a third step we attempted to remove Travis from the room for a time-out. At this time Travis became more aggressive and refused to take his hands off the other child. For the safety of the other child and the rest of the group, Travis had to be physically removed from the child, and from the room. Because Travis's behavior continued to escalate, step four was taken, and he was removed from the group for that session, and he and his mother left the session early. As an important follow up step, Siepker and Kandaras (1985) note that it is important that the child continues to feel supported despite his behaviors and his removal from the group, and that the therapist should see the child apart from what he does. Following the incident, and as Travis was calming down, I let him know that I continued to like him as a person, and was looking forward to seeing him the following week.

In addition to comforting Travis, the feelings of the other children who experienced the incident were addressed. Some of them expressed feeling scared and uncomfortable with Travis's behaviors following the incident. The children were told that Travis's behavior was inappropriate, unsafe, and unfair for them to be subjected

to. We told them that Travis's behaviors would not be accepted in future groups, and we would remove him from group permanently if he acted in a similar way again. This conversation appeared to be helpful for the children as they were able to express and debrief their feelings.

Following this incident in order to address Travis's inappropriate behaviors, a meeting was organized with Travis and his mother Marsha, and a plan was implemented for Travis. He was told that his behavior was not appropriate for group because he was compromising the safety of the children in the group. He was told that the next time he initiated any aggressive behaviors towards another child, he would be given a time-out, and if he did not comply then he would be removed from the group. Following the meeting with Travis and Marsha, Travis was more compliant with the rules and he listened to the facilitators in the group context.

Following the meeting with Travis and Marsha, another technique called "1-2-3-magic" was utilized with Travis in the group. Anytime Travis initiated any inappropriate physical contact with another child, the facilitators would apply this technique by counting to three. This technique was implemented as a way to inform Travis of when he was engaging in inappropriate behaviors, and to educate him about new more healthy behaviors. Travis would often stop his rule-breaking behavior at the count of two, as he knew the consequences of getting to three would be a time-out. Usually, when a child is hurting another child, 1-2-3-magic is not appropriate. With Travis however, his behaviors would always begin with playful contact, which would at times be initiated by another child towards Travis. However, while the other children knew when to stop, Travis's behaviors would escalate to a more aggressive

and out of control state. Therefore we felt comfortable counting to three with Travis, because initially he would not be hurting the others. Out of the three strategies applied to dealing with Travis's aggressive behaviors, including time-out, positive reinforcement of good behavior, and 1-2-3-magic, 1-2-3-magic seemed to work the best.

According to Lampel (1985), children's anxiety levels will be high during the first few meetings, and they will often act out in order to find out where they belong in the group. This appeared to be true for Jeremy, Rob, and Travis. As the group began, Jeremy and Rob seemed to make a connection with each other. This was evident in their behaviors and interactions with each other, as they would often be silly and disruptive in the group, and would often act out to impress each other. For example, during one session Rob said to Jeremy "Hey Jeremy, look at me, I'm a cat", and he performed a silly imitation of a cat. Jeremy laughed at Rob and then copied him. Travis also did an imitation of a cat in an attempt to fit in with the others. It appeared therefore, that all three boys were acting silly in an attempt to impress each other, and to find their place in the group.

This behavior appeared to work for Rob and Jeremy, strengthening their bond and increasing their comfort level within the group, however Rob and Jeremy did not appear to respond to Travis's attempts at getting close with them. Travis made many attempts to fit in with them, laughing when they laughed, imitating their silly behaviors, and acting out to impress them, however his efforts did not seem to be enough to fit in. Travis had a difficult time pronouncing words, and he had a difficult time remembering things such as rules to games and people's names. At times, the

others in the group appeared to get frustrated by these behaviors and at times made fun of him. Travis's failed attempts to fit in may have led to his aggression towards the others. Travis's aggression seemed to scare the others, which removed him even further from any potential connection with Rob and Jeremy. Therefore as Rob and Jeremy appeared to be making some progress, Travis did not appear to be progressing, potentially resulting from his inability to fit in.

The rules of the group were clearly outlined at the beginning of the group, and for the most part the children abided by them. When Travis or any other child was breaking a rule, the behavior would be brought to the attention of the group, and the group would review the rule that was being broken and the importance of maintaining the rule. This provided the children with education about appropriate behaviors, and allowed them a safe environment to practice what to them may have been brand new behaviors. It appeared that the others in the group were aware that Travis's behaviors were extreme as he created much disruption in the group.

As the children struggled to find their place in the group, their behaviors were often disruptive. One technique used when the children were acting silly, and was helpful to avoid getting into a power struggle with them, was to go along with them and take part in their silly behavior. For example, during one session, Jeremy started to make noises with his lips, and the others copied him. Instead of attempting to stop the behavior and refocus the children, they were encouraged to continue with the noises and the facilitators joined in. Games were created to incorporate the noises, such as who can make the loudest or most quiet noise. Important to note is that although the children were behaving in a silly manner, I was in charge and was

maintaining a safe and consistent environment. Once I took charge of the behavior, it became easier to stop.

Also important, while the children are finding their place in the group, is to respond to their behaviors and let them know that they are important (Lampel, 1985). For example, when Rob was doing a cat imitation, I laughed and told him that he was funny. After a moment of humor, I attempted to refocus Rob telling him that he should be respectful of others when they are talking. Therefore, I supported Rob's humorous behavior, but I set limits on his disruptive behavior. According to Lampel (1985), children's anxieties will begin to diminish once they feel that they are important members of the group.

A fourth group member, Brooke, was fairly quiet and removed as the group began. She did not contribute to conversations unless she was asked, and she appeared a little bit uncomfortable. By session three, Brooke was much more outgoing, was eager to contribute to conversations, and was enthusiastic in offering answers to questions. She also appeared much more comfortable, and did not let the boys in the group intimidate her. Brooke's presence as a female appeared to add an element of calmness to the group. The boys were slightly more reserved and cautious in her presence. I do not believe that this had a significant influence on the progress of the group, but rather added a level of maturity to the group that may have not been there without the presence of a female. Although Brooke was not part of Jeremy and Rob's alliance, this did not seem to affect her, as she was independent and secure on her own.

Session topics in this stage of group included "Getting to Know Each Other" in meeting one, "Feelings" in meeting two, and "Different Kinds of Hurting" in meeting three. Throughout each meeting children's behaviors were addressed keeping the framework of developmental psychopathology in mind. For example, it was understood that group members had a unique set of risk and protective factors that had influenced them and therefore contributed to their unique behavioral outcomes (Rutter & Sroufe, 2000). Each child was different and therefore required a different approach to intervention (Sameroff, 2000), and the various backgrounds of the three explanatory theories contributed to the various intervention strategies utilized. For example child witnesses to domestic violence have been influenced by what they have been exposed to in their home, and their thoughts and behaviors reflect this (Bandura, 1977). Therefore, children in the group were provided with education and information in each session with the hope that they would begin to restructure their cognitions to include more healthy and adaptive ones. According to Bandura (1977) thoughts mediate behaviors, therefore by teaching more positive information the children may choose more healthy behaviors as well. In addition, the facilitators provided the children with rules and enforced them and provided positive role models for the children so they could learn new more appropriate behaviors and practice them in a safe environment.

Children who have been exposed to domestic violence may exhibit PTSD symptomology including becoming easily startled, or having increased sensitivity to their surroundings (Levendosky et al., 2002). Therefore, in the group it was important to maintain structure and predictability. At the end of each session, the

children and their mothers came together for the multifamily portion of the group. This occurred for the last forty-five minutes of each meeting. Because poor attachment is common between mothers and children from families characterized by family violence (Graham-Bermann & Levendosky, 1997), this portion of the group was very important for building that connection. Some families may have lost the attachment between mother and child when violence began, whereas other mother-child dyads may not have formed an attachment at all due to domestic violence in the home since birth of that child. Therefore, the activities that the mothers and children engaged in during the multifamily portion helped to build and/or strengthen their attachments. A detailed description of what occurred in the multifamily portion of the group is beyond the scope of this practicum.

Stage III: Anxiety

According to Brandler and Roman (1991), in order to move forward and begin to work on some of their presenting issues, the children must feel safe and secure in the environment of the group. By approximately session four, Rob, Jeremy, and Brooke all appeared to be feeling comfortable in the atmosphere of the group, in the company of the other group members, and with the facilitators. Travis also appeared to be settling into the group after his behavioral outburst the session earlier, as he was following the rules more closely by responding to the 1-2-3-magic intervention, and he was continuing his attempt to get along with the other group members. Rob and Jeremy were also attempting to include Travis in their growing friendship.

During this stage, some of the children in the group began to take on certain roles, which is common in children's groups (Northen, 1969; Scheafer et al., 1982). Rob

emerged as the clown of the group, making everyone, including the facilitators, laugh. This behavior was at times disruptive, however also a fun component of the group. Rob also played the role of leader during this stage, and he appeared to have an influence over some of the other group members. For example, I had a discussion with Rob regarding Travis's outburst the week before and how Travis may feel uncomfortable coming back to group after what had happened. I asked Rob if he could try to include Travis and make him feel more comfortable in the group. Rob agreed that this would be a good idea, and he attempted to include Travis. Travis responded well to Rob's attention, and the two appeared to get along well. As Rob shifted his attention to include Travis, Jeremy also began to include Travis in conversations and activities. Up to that point, I had not seen Jeremy engage with Travis, so it appeared that Jeremy was influenced by Rob's behavior.

During the conversation that I had with Rob, I also addressed the disruptive nature of the silly behaviors that he and Jeremy were engaging in, and discussed that at times these behaviors were disruptive, and that he should try to be more respectful when others in the group were talking. (I intended to have this conversation with Jeremy as well, however an opportunity did not present itself). In the group that evening, when Jeremy attempted to disrupt Rob, Rob did not respond to the degree that he had in previous sessions. As a result of this, Jeremy did not provoke Rob as much. Here again was evidence of Rob's influencial role as leader. Rob's behaviors also contributed to group cohesion, and ultimately group progress, as he attempted to include Travis in his relationship with Jeremy.

Brooke brought insight, wisdom, and kindness to the group. During one situation, Brooke offerred advice to the other group members who were expressing feelings of despair regarding their families. Rob and Jeremy were commenting how they did not feel that they had a family because their dads were not living with them. Brooke intervened by saying "My mother told me that even though my dad isn't living with us, we are still a family". The boys nodded to her statement and agreed with her. Brooke was able to offer some insight to the other group members, which if said by a facilitator would not have had as much of an impact (Glass & Thompson, 2000).

At this stage of the group, there appeared to be some progress in terms of how the children were responding to the content of the sessions, and to each other. Although the children continued to show signs of anxiety such as covering up with a blanket during a story, leaving the circle, or interrupting conversations with unrelated stories, they were sharing their thoughts and feelings with the group, group members were offering each other insight, and they were incorporating the content of the sessions into the crafts and activities.

Although further progress was expected, two things happened which delayed the progress of the group. First, Rob began to act more defiant and unusual. He attended one session with sunglasses on, and removed his outer layer of clothing to reveal summer shorts and a tank top. During this particular session, in addition to his unconventional physical appearance, he also displayed uncharacteristic behaviors and attitudes. Compared to his actions and behaviors in the first stage of group, Rob was not being as friendly towards Jeremy, he was not trying as much to make the rest of the group laugh, he was not contributing to the same extent to conversations, he was

not taking part in the crafts and activities with the same enthusiasm, he began to make comments that the group was boring, and he became more defiant during this middle stage of group. Since Rob had played such an important role in the group up to this point as a leader and as a main player in building group cohesion, his unusual behavior proved to be harmful to the group in terms of the progress that had been made thus far, and any group cohesion that had developed. Rob discontinued attempts at including Travis in conversations and activities, and actually began to antagonize him. Without Rob's attemps at inclusion, Travis was left out. Also, Rob was disconnecting from Jeremy, which was an important sub-unit that up to this point had been contributing positively to group cohesion.

During this time, Jeremy, Brooke, and Travis expressed that they felt uncomfortable with Rob's behavior and appearance, they expressed frustration with his behaviors, and they questioned him as to the origins of his behavior. I encouraged these conversations, so that Jeremy, Travis, and Brooke could get answers to their questions, and so that Rob could get some insight into how his behavior was affecting the others in the group. One of the strategies that had been incorporated into the group earlier that proved helpful at this point in time was positive reinforcement for expressing your feelings. According to social learning theory, people repeat behavior if it results in a positive and rewarding outcome (Bandura, 1977). This activity encouraged the children to use their words to solve their problems as opposed to using their hands or other physical means. For example, if someone in the group did something innappropriate to someone else, they were encouraged to say how they were feeling about it, and they would get a reward of candy for expressing their

feelings. The children used this strategy when Rob was evoking certain feelings for them. For example, when Rob was not following the rules to a game and was ruining the game for the rest of the group, Jeremy expressed that he was feeling angry with Rob. The children appeared to feel empowered by these expressions of feelings.

According to Siepker and Kandaras (1985) when a child is acting out, the therapist should show continued support despite any negative behaviors. I attempted to support Rob, however seeing how his behavior was upsetting the other group members, and affecting the dynamics of the group, I became frustrated with his behavior. As the others in the group were expressing their frustration and anger with his behaviors which were disrupting games and activities, I also expressed my feelings of frustration, saying at one point, "Rob, your behavior is making me angry too". Although it may have been beneficial to express my feelings to Rob, as it modelled to the other children how feelings can be expressed appropriately, I should have also in some way expressed my continued support for him despite his discouraging behaviors. I fear that my frustrations with his behavior were more prominent, and I did not provide him with enough support.

Rob's behaviors fluctuated throughout the remainder of group, and his feelings towards Jeremy were unpredictable with each new session. Jeremy appeared a little cautious and confused at Rob's behavior. Although Rob's behaviors did impact the progress of the group as a whole, it appeared that Jeremy and Brooke were able to make continued progress at an individual level.

The second incident that impacted the group's progress at this stage was the expulsion of Travis from group. This occurred following an incident where Travis

lost control of his aggressive behaviors for a second time. Due to the plan that had been implemented with Travis and Marsha, and because Travis's behavior jeopardized the safety of the others in the group, Travis had to be removed from the group. According to Lewis (1985) if children are not able to form the necessary close relationships that are required at this stage in the group, instead of dropping out themselves, they may need the therapist to make this decision for them. In Travis's case, the desire and motivation that his mother had in attending the mother's group may have encouraged Travis to attend the children's group even though he was not fitting in with the others in the group, and the group was not meeting his needs. Therefore it was important for us to make the decision to remove Travis from group. Travis was referred within EHCC for different services that could address his individual needs.

The incident proved to be a traumatic experience for Rob and Jeremy, and impacted the progress of the group by changing the group dynamics, and by disrupting the stability and safety of the group in the eyes of the children. During the incident Travis had to be restrained due to uncontrollable physical aggression towards Rob, and he yelled threats at Jeremy and Rob (Brooke did not attend this particular session). Just following the incident, Jeremy hid under a desk and asked if Travis was going to come out and hurt him, and both Jeremy and Rob appeared physically to be shaken by the incident. The incident was discussed with the children and their mothers directly following Travis's departure. It was important to be honest and up front with them, telling them the consequences of Travis's actions, and giving them the opportunity to discuss their feelings (Lewis, 1985). Each of the children

expressed their fear of Travis, and their happiness that he would not be returning to group.

Each child adjusted to Travis's removal from group in their own way. Brooke did not appear to be impacted by the turn of events, however both Jeremy and Rob seemed to be affected. According to Lewis (1985) following a group member's removal, feelings of fear may develop where the other children may feel that they will be next to go. This was evident in Rob's behavior in the session following Travis's removal from group. First, Rob expressed that he was angry that Travis was no longer in the group, and during an activity when he was not following the rules, he asked if I was going to "kick him out too" for being disobedient. At this point I explained again the reasons why Travis was not able to return to the group, and that although Rob was breaking the rules, his behavior was not extreme enough to have him removed from group. Lewis (1985) also explains that children often act out to test their limits and to test if the therapist can be trusted. Both Rob and Jeremy were testing the limits by behaving in inappropriate ways. Also, children may be happy with the removal of a child from group, as they realize the damaging nature of the child's beahviors (Lewis, 1985). Jeremy expressed that he was happy that Travis was gone, saying that he did not like it when Travis got aggressive and angry.

Travis's removal from the group therefore slowed the progress of the group, as the children had to readjust and find a new level of comfort. After the children regained their level of security and their place in group however, the group was more easily able to build group cohesion without the inclusion of Travis. Rob's unusual behaviors also threatened group cohesion and group progress initially because of

Rob's influential position in group. However, Rob's changing behaviors did not have a lasting impact. Jeremy relied less on Rob to have a good time in group, became an independent person, and began to bond with Brooke in the absence of Rob's comradary. Brooke welcomed Jeremy's initiations and the two became friends. Rob's behaviors and attitudes fluctuated, as did his friendship with Jeremy.

Another important component that emerged in this stage and which helped each individual group member progress, was the inclusion of the parents in the therapeutic process. According to Lewis (1985) if a parent is unable to progress through this stage successfully, this will decrease the chances that their child will successfully pass through this stage. The fact that the mothers of the children in the group took part in their own group, increased the chances that their children would make progress. The mothers were educated about how the abuse they experienced may have affected their children's emotions and behaviors, and they were able to get support and ask questions regarding the problems they were having with their children. The support that they were given in their group helped them to deal with the changes that were happening with their children as a result of their inclusion in the children's group. This continued support for the mothers helped them to be better supporters of their children, and helped to ensure that the external environment supported the therapeutic process, and that success could be continued beyond the therapy room.

Through supervision sessions, I was given feedback on a weekly basis regarding the progress of the mothers. I found this component to be a very important one in terms of understanding any progress or regression that the children experienced

during group. Unfortunately, inclusion in a therapy group for two hours every week cannot override the influence that the external environment has on the children, and if the mothers were not making progress, the children would also be stagnant in their progress (Lewis, 1985). This appeared to be the case for Rob and Juli. Through supervision sessions, I learned that Juli was having a difficult time understanding some of Rob's behaviors, and she was struggling to incorporate what she was learning in the group with Rob's experience as a witness of domestic violence. This inability of Juli to make the connection between Rob's experiences and his behaviors may have contributed to Rob's difficulty making progress in group, as he may not have had strong support from his mother. In addition, Rob and Juli did not appear to have a close connection, which may have been due to the personal circumstances occuring for Juli at the time of the group. In addition to dealing with Rob's difficult behaviors, Juli was going through a custody battle and was struggling financially. According to research, increased maternal stress as a result of domestic violence may lead to higher levels of internalizing and externalizing behavior problems for children (Levendosky & Graham-Bermann, 1998).

Although a difficult task, the children were able to work their way through the anxiety stage. According to Lewis (1985) the anxiety stage comes to an end when children have built trusting relationships with each other and with the therapist. Although Rob, Jeremy, and Brooke continued to exhibit anxious behaviors, they appeared to have made a connection to each other and to the group. They expressed happiness with the group and their inclusion in it on many occassions. For example, even as Rob was behaving unusually and was not connected to the other group

members, he expressed that he enjoyed coming to group each week. Also, during the multifamily portion of the group the children took pride in explaining to their mothers what they had accomplished in group that evening. When the children greeted each other at the beginning of each session, and when they said goodbye, they appeared happy with their new friendships that were unique and special to them.

Session topics covered in this stage of group included "Fighting in Families" as session four, "Fighting in Families Should Never be a Secret" as session five, and "Mixed-Up Feelings" as session six. Different strategies used during these sessions that emerged from a combination of the explanatory theories included debunking myths and restructuring unhealthy thoughts which occurred when discussing responsibility for the violence; self-esteem building and breaking down the sense of isolation when "breaking the secret" was discussed; modeling of positive behaviors during role plays and puppet shows; practice of healthy behaviors from the children; and building of attachment through the multifamily portion of the group.

Stage IV: Cohesion

The cohesion stage did not stand out as a distinct stage that occurred at a particular time in the group. In fact, it appeared that the group transitioned from the anxiety stage directly to the termination stage. This may have occurred for a few reasons. First, instead of having twelve sessions to work with, the group was only ten sessions in duration, which decreased the amount of time available for the group to move through the stages. Second, it took the children a while to feel comfortable in the group due to changes that threatened the group's stability, including Rob's altered behaviors and Travis's removal from the group. Third, the onset of termination

occurred before the group as a whole was able to become cohesive. According to Herndon (1985) when children are informed of the group coming to an end (which is recommended when there are three sessions left out of a twelve-session group), they often regress both individually and as a group. Therefore, just as the children were able to regain stability they were de-stabilized again with the knowledge of the group's upcoming end. Therefore, there did not appear to be one particular time frame where the group was most cohesive.

Although there did not appear to be a distinct stage where cohesion was prevalent, and the group as a whole did not seem to become a cohesive unit, there were definitely some cohesive sub-units formed within the group. For example, Rob and Jeremy bonded to form a cohesive unit during the first half of the group, and Jeremy and Brooke became close as the group was coming to an end. There were also aspects of the group that illustrated cohesion. According to Kandaras (1985) a group is cohesive when children feel comfortable to share with the others in the group, and when children listen respectfully and respond to the other group members' stories. This was the case in the children's group. As the children shared their issues with the group, they revealed their concerns and asked questions, and they listened and respected advice and comments from the other children in the group.

According to Kandaras (1985) during the cohesion stage of group development, anxiety is still present, but it is occurring within each child individually and is not a controlling factor for the group. This was the case for Brooke and Jeremy as the group was entering its last stages of development. Jeremy continued to exhibit anxious behaviors such as interrupting discussions with irrelevant stories, and hiding

under a blanket during a story. Brooke also appeared anxious at times, as she was restless and left the circle occasionally during conversations. Rob also exhibited anxious behaviors as the group was working through the final stages, however his behaviors were not independent of the group, as they had an impact on the group as a whole. For example, Rob would not participate in crafts or activities, he would leave the room, and he would criticize and put down the efforts of the others in the group. Rob's behaviors made it difficult for the group to bond as a whole, however Jeremy and Brooke appeared to be progressing and were thriving on an individual level.

Session topics included in this stage of group included "Feeling Afraid" as session seven, "Angry Feelings" as session eight, and "Getting Along With Others" as session nine. During this stage of group the children were educated about being afraid, and a safety plan was reviewed with them. More education and the opportunity for a change in belief patterns occurred around the topic of anger in the form of role plays, stories, and puppet shows. In addition, appropriate ways of getting along with others was modeled for the children by the facilitators, and they were also given the opportunity to practice themselves.

Stage V: Termination

On the third last session the children were reminded that the group would be coming to an end soon, and each following week the children were again reminded of the imminent end of group. The children had mixed feelings about the group ending. They said they were both happy and sad. Some expressed that they would miss the friendships made in the group, and others said they would miss the games and snack.

Some said they would be happy when the group was over, because they felt they had learned a great deal.

According to Fatout (1996) this stage should be used by the facilitator to evaluate the progress of the group members, and to decide whether or not they are ready for termination. Of the three group members who remained at the end, Brooke and Jeremy appeared to have made sufficient progress. It appeared that they would both be able to maintain and improve upon the success that was gained in the group and would be able to extend it beyond the group. Rob however did not appear to make the same progress in the group as the others. Rob's behaviors and attitudes indicated that he was not thriving in the group atmosphere and as the group progressed Rob appeared to be regressing.

According to Herndon (1985) children may display separation and coping reactions as the group is coming to an end. Herndon (1985) mentions anger, regression, hostility, and acting out as possible reactions that children may engage in. Rob engaged in all of these reactions as the group was coming to an end. However, Rob's behaviors changed to become more angry and hostile during the middle of the group, before any mention of group coming to an end. Other external factors may have contributed to his changing behaviors.

According to Herndon (1985) as the group is coming to an end, it is important for the facilitator to reminisce about the group, and to outline all that was accomplished in the group in order to facilitate closure. As this task was accomplished in the group, the children appeared to enjoy recapping all of their favorite activities, and were excited to review what they had learned. Also important as the group is ending is to

assist the children to look beyond the group to their future (Herndon, 1985). This was carried out as the children worked on the picture frames they would be giving their mothers on the last session. We discussed where they would put the frames in their homes and how the frames could remind them about all of the special and fun times that we had in the group.

In the last group session Rob refused to make a frame for his mother, and he also appeared to be sabotaging the efforts of the others in the group. Jeremy seemed to be impacted by Rob's insults and put-downs. At one point Jeremy stopped working on his frame and said, "Well, now mine is ruined" after Rob did not lend him something to complete his frame. Jeremy handled Rob's criticisms well though, and continued to work on the craft, appearing proud of the final product. Brooke also handled Rob's behaviors well. She expressed her feelings in a mature and matter of fact way, saying to Rob "You are being mean" and "Why are you acting this way?" She also complimented Jeremy's frame many times to make him feel better. As the group ended both Jeremy and Brooke appeared content and comfortable with themselves. Jeremy was more confident and had become his own leader as opposed to relying on Rob. Rob was acting hostile and argumentative, and expressed many times that he was not having a good time.

Session ten entitled "Saying Goodbye" was the last session of the group. During a closing ceremony, the children were presented with certificates of completion, "I am special" stars, a small present from the facilitators, and a T-shirt from their mothers. The group shared cake and discussed their feelings about group ending.

Stage VI: Closure

After the last group session, follow-up meetings were arranged for all of the mothers in the group. This meeting included a review of their child's progress, a discussion of their child's experience in group, recognition of their child's strengths, and any concerns regarding their child that were revealed in the group. In addition, the results of the evaluation measures were reviewed and discussed with the mothers. The clinical observations of the child's progress was combined with the results of the quantitative measures completed by the mother and child, and the mother's perspective, to determine whether the child required follow-up services. Feedback from the mothers was important at this point to see how their child was functioning external to the group with respect to the issues with which they presented.

Evaluation of the Multifamily Group Members

In the following section, the quantitative and qualitative measures will be combined with clinical observations for each child in order to analyze their progress in the group.

Jeremy

Results from the pre-test administration of the Piers-Harris indicated four cluster scale scores that were in the clinically significant range (i.e., below the 16th percentile) including "behavior", "anxiety", "popularity", and "happiness and satisfaction". Therefore, Jeremy's self-evaluation in these four domains was low. The total score was also in the clinically significant range, indicating that in general, according to the guidelines set out by the Piers-Harris, Jeremy had low self-esteem.

In the post-test administration of the Piers-Harris, the scores were improved with only two cluster scale scores in the clinically significant range, including "popularity" and "happiness and satisfaction". All but one of the cluster scores increased from pre-test to post-test. The only cluster score that decreased was "popularity", which decreased slightly from the 32nd to the 29th percentile, and remained clinically significant at both test administrations. The total score increased from a T-score of 39 in the pre-test which was at the 15th percentile to a T-score of 42 in the post-test which was at the 22nd percentile. Jeremy's answers at post-test indicated that he had a more positive self-evaluation in the domains where the scores increased, however the increases were minimal and his total score at post-test was only 7 percentile points greater than the score at pre-test. Therefore, the post-test scores of the Piers Harris indicate that Jeremy continued to have a fairly low or negative self-concept (see Table 1).

Results from the pre-test administration of the CBCL indicated one score that was in the clinical range, "withdrawn/depressed", and one score that was in the borderline clinical range, "social problems". The remainder of the scores were in the normal range, as was the total score. Results for the post-test showed one score in the clinical range, "withdrawn/depressed", and the remainder of the scores were in the normal range, as was the total score. The score for "withdrawn/depressed" increased slightly from a T-score of 75 to a T-score of 82 from pre-test to post-test. The total T-score for internalizing behaviors was 68 at pre-test and 68 at post-test, and the total T-score for the externalizing behaviors was 62 at pre-test and 51 at post-test (see Table 2). It appears that following the group, Jeremy did not show improvements with respect to

Table 1

Total T Scores and Cluster Scores for the Piers-Harris at Pre-test and Post-test for Children Attending the Multifamily Group

	Jeremy		Brooke		Rob	
	Pre	Post	Pre	Post	Pre	Post
Total Score	39	42	62	60	40	62
Percentile	15	22	88	84	16	88
I. Behavior	39	43	54	50	23	47
II. Intellectual and School Status	47	50	63	55	45	63
III. Physical Appearance and Attributes	46	49	60	60	46	64
IV. Anxiety	34	44	63	59	47	69
V. Popularity	32	29	55	41	41	61
VI. Happiness and Satisfaction	30	36	56	63	36	63

Note. T-scores are reported. Higher T-scores indicate a higher self-concept. Scores at or below the 16th percentile are considered clinically significant.

Table 2

T scores for the Child Behavior Checklist at Pre-test and Post-test for the Multifamily Group

	Jeremy / Jane		Brooke / Anne		Rob / Juli	
	Pre	Post	Pre	Post	Pre	Post
Total Score	63	61	75	68	75[a]	78
Internalizing	68	68	70	63	73[a]	66
Externalizing	62	51	76	71	79[a]	81
I. Anxious / Depressed	59	62	68	65	72[a]	69
II. Withdrawn / Depressed	75	82	66	55	74[a] (Withdrawn[b])	66
III. Somatic Complaints	64	52	66	60	60[a]	50
IV. Social Problems	66	59	78	75	73[a]	88
V. Thought Problems	51	60	70	58	57[a]	73
VI. Attention Problems	55	53	79	64	74[a]	75
VII. Rule-Breaking Behavior	57	51	66	55	70[a] (Delinquent Behavior[b])	76
VIII. Aggressive Behavior	64	52	85	76	90[a]	94

Note. T-scores are reported. All T-scores above 63 are in the clinical range, T-scores between 60-63 are in the borderline clinical range, and T-scores below 60 are in the normal range.

[a] These results were from the Child Behavior Checklist for children ages 4-18 (Achenbach, 1991), therefore direct comparisons with the post-test results from the CBCL/6-18 may not be made in this case.

[b] Sub-scale titles for the CBCL/4-18 which differ slightly from the CBCL/6-18.

internalizing behavior problems, but showed slight improvements with respect to externalizing behavior problems.

Results from the post-group children's evaluation indicated that Jeremy liked the group "a lot" including the activities, and he said that he enjoyed learning new strategies such as "how to manage my anger". In the post-group mother's evaluation of the children's group, Jane expressed that the group helped Jeremy "a lot", and that she noticed changes in Jeremy as a result of participation in the group. Jane noted that Jeremy had learned to open up more as a result of the group, he was not as distant as he had been, and he did not get as angry as he used to. During the follow-up meeting, Jane expressed satisfaction about her and Jeremy's involvement in the group, saying that his aggressive behaviors had decreased, and the bond between her and her son had been strengthened. Jane expressed that she was very pleased with the group and she felt that the group "gave me my son back". Jane also expressed concern regarding Jeremy's self-esteem, saying that it had been continually decreasing. These concerns were supported by the results of the CBCL where the total score for externalizing behaviors had decreased, but the total score for internalizing behaviors remained the same from pre-test to post-test. In addition, although the scores on the Piers-Harris improved slightly from pre-test to post-test, they remained fairly low at approximately the 22nd percentile at post-test.

In addition to the measures suggesting a low self-esteem, Jeremy discussed some issues within the context of the group that may have indicated problems in this area. For example, on one occasion he expressed that he had few friends, and on another occasion he expressed a desire to lose weight. In addition, throughout the majority of

the group, Jeremy appeared to be a bit of a follower in his attempts to fit in and make friends, and his behaviors were at times disruptive to the group when he was trying to impress the others. All of these components therefore support Jane's concerns of low self-esteem in Jeremy. Observations of Jeremy's behavior at the end of group however indicated that he might have gained self-esteem and self-respect in the context of the group. By the end of the group, Jeremy appeared to have become more comfortable with himself and less interested in the approval of others. He was less willing to be a follower and depend on the others, and instead appeared to be a leader and depended on himself. For example when Rob behaved in a disrespectful manner towards Jeremy, Jeremy verbalized his opinions to Rob and then proceeded to befriend Brooke. He continued to be nice to Rob, however he did not allow Rob's behaviors to dictate his behavior. By the end of the group therefore, it appeared that Jeremy was developing an increased level of confidence and pride in himself. Although Jeremy began to show a level of self-confidence as the group was coming to an end, this is an area that will require continued efforts. As a result of attending the group though, Jeremy's aggressive tendencies decreased, he and his mother became closer, and the group gave him a chance to build his self-esteem in a safe atmosphere. These components may all be used to help Jeremy increase his self-esteem in his external environment. Following the meeting with Jane it was determined that there was no need for further involvement with EHCC.

Brooke

Results from the pre-test administration of the Piers-Harris indicated all cluster scores in the normal range with a total T-score of 62 which was at approximately the

88th percentile. Therefore, according to the Piers-Harris, Brooke had a positive self-concept at pre-test. Results from the post-test indicated all cluster scores in the normal range, except for one "Popularity" which had decreased from a T-score of 55 in the pre-test to a T-score of 41 in the post-test. The total T-score at the post-test was 60, which was at the 84th percentile. Therefore, Brooke had a more negative self-evaluation of her popularity at the time of the post-test, however her overall self-esteem remained at a high level.

Results from the pre-test administration of the CBCL showed four scores in the clinical range including "social problems", "thought problems", "attention problems", and "aggressive behavior", and four scores in the borderline clinical range including "anxious/depressed", "withdrawn/depressed", "somatic complaints", and "rule-breaking behavior". At pre-test there were no scores in the normal range. Therefore, Anne felt that Brooke was exhibiting all of the behaviors outlined in the measure at problematic levels. The total T-score for internalizing behavior was 70 and the total T-score for externalizing behavior was 76. Results from the post-test indicated two scores in the clinical range including "social problems" and "aggressive behavior", one score in the borderline clinical range, "anxious/depressed", and the rest of the scores in the normal range. The total T-score for internalizing behavior was 63 and the total T-score for externalizing behavior was 71 at the post-test. There was a decrease in every score from pre-test to post-test, and six scores went from the clinical or borderline clinical range to the normal range. In addition, the two scores that remained in the clinical range at post-test decreased, with "social problems" going from a T-score of 78 at pre-test to a T-score of 75 at post-test, and "aggressive

behavior" going from a T-score of 85 at pre-test to a T-score of 76 at post-test. Following group therefore, Anne found Brooke to be functioning more effectively in all areas observed by the measure.

Results from the post-group children's evaluation indicated that Brooke liked the group "a lot", especially when the mothers and the children were together. In the post-group mother's evaluation of the children's group Anne expressed that she felt the group helped Brooke "a lot". Anne felt that as a result of the group Brooke realized she was not alone, and that neither she nor her mother was to blame. Anne noticed changes in Brooke as a result of participation in the group, including an increase in her confidence, a decrease in her aggressive behavior, and her "true loving nature" showing more often. A suggestion made by Anne included informing the parents about the purpose of the games in the group and why they were helpful. During the follow-up meeting with Anne, she expressed her pleasure with the group and with the progress that she and Brooke had made.

Brooke made exceptional progress in the group. She was initially quiet when she entered the group. She appeared to be absorbing what was happening around her and getting comfortable with the other children. Her quiet demeanor may have been because all of the other group members were boys, who were louder and more rambunctious that she was. In addition she did not seem to have a lot in common with the others in the group. She would talk when asked a question but would not offer too much on her own. As the group progressed, Brooke opened up more and contributed to group conversations. While the others continued to be loud and rambunctious, she raised her hand high when she wanted to talk and was not afraid to

speak her mind. She ended up offering many insightful contributions to group conversations, and appeared to be an extremely confident, perceptive, supportive, and positive child.

At the post-group follow-up meeting, Anne expressed that as a result of the group she gained empathy for Brooke and she understood where she was coming from. In addition, Anne expressed feeling more in control within the relationship thereby reducing the power struggles with Brooke. Many positive changes were seen for Brooke and Anne. Brooke appeared to gain knowledge about family violence, and the bond between mother and daughter appeared to be strengthened. After the follow-up meeting it was determined that there was no need for further therapeutic involvement with this family through EHCC.

Rob

The pre-test administration of the Piers-Harris showed two cluster scale scores in the clinically significant range (i.e., below the 16th percentile) including "behavior" and "happiness and satisfaction". The T-score for "behavior" was extremely low at 23, indicating that Rob's self-evaluation of his behaviors was extremely negative. The rest of the scores were below the 50th percentile, and the total T-score was 40 (16th percentile). The lower cluster scale scores indicated that Rob did not perceive himself to be excelling in any of the areas, and the lower total score indicated that he had low self-esteem. The post-test showed all of the scores above the 50th percentile except for "behavior", and the score for "behavior" had increased to a T-score of 47 at the post-test. The total T-score at post-test was 62 (88th percentile). This dramatic increase in all of the scores may have indicated one of two things: that Rob's self-

esteem increased significantly, or that he answered the questions in a defensive or a socially desirable way at the post-test (Piers, 1984). In my opinion, Rob was responding in a socially desirable way in order to parlay to me that he felt that he was doing well. It was clear however that he was not doing as well as he reported on the Piers-Harris. This was determined by the fact that Rob's behaviors deteriorated as the group progressed and by the occurrence of negative interactions between him and his mom during the multifamily portion of the group. In addition, Rob had reported negative comments about his mom in the group setting discussing his unhappiness, and Juli had discussed her frustrations with his behaviors in the women's group. Therefore, Rob's answers on the post-test did not match the observations that I made of him as the group was coming to an end.

The pre-test administration of the CBCL that was administered to Juli was an older version of the scale for children ages 4-18. This version of the test was the only one available at the time. Because this test differs from the test administered at the post-test (CBCL/6-18) direct comparisons would not provide an accurate analysis. However analysis of each one separately may provide some insight. At the pre-test administration there were five scores in the clinical range including "withdrawn", "anxious/depressed", "social problems", "attention problems", and "aggressive behavior", one score in the borderline clinical range ("delinquent behavior"), and two scores in the normal range including "somatic complaints" and "thought problems". Therefore, Juli felt that Rob was having a difficult time functioning in all but two areas. The highest score was for the scale "aggressive behavior" with a T score of 90.

This indicated that Rob's aggressive behaviors were causing the most problems for Juli.

The T-score for internalizing behavior was 73, the T-score for externalizing behavior was 79, and the total T-score was 75. Each of the total scores were in the clinical range indicating a significant level of difficulty for Rob overall. Rob's perception of himself as reflected in the scores on the Piers-Harris appeared to be similar to Juli's perception of Rob as outlined in the CBCL. There appeared to be consensus between Rob and Juli as to where the problems were and their degree of seriousness. Both measures identified behavior as the main issue for Rob. Rob had an extremely low score on the "behavior" scale of the Piers-Harris indicating a negative perception of his behavior, and Juli had an extremely high score on the CBCL indicating behavior to be a problem area for Rob.

The post-test administration of the CBCL was for children ages 6-18. This scale showed five scores in the clinical range including "social problems", "thought problems", "attention problems", "rule-breaking behavior", and "aggressive behavior", two scores in the borderline clinical range including "anxious/depressed" and "withdrawn/depressed", and one score in the normal range including "somatic complaints". The T-score for internalizing behavior was 66, for externalizing behavior was 81, and the total T-score was 78. All of these total scores at post-test were in the clinically significant range, and the T-scores for "aggressive behavior" and "social problems" were both very high at 94 and 88 respectively. The scores on both the pre-test and post-test administrations of the CBCL showed similar trends, with clinically significant scores in all areas including internalizing behaviors,

externalizing behaviors, and the total score. In addition, both tests showed elevated scores for the "aggressive behavior" scale. The results from the scales indicated that Juli did not see any significant changes in Rob's behaviors as a result of the group. The results of the Piers-Harris at post-test showed that Rob had a higher perception of himself following his inclusion in the group, with all of the cluster scale scores increasing large amounts from pre-test to post-test and the total T-score increasing 22 points with an increase of 72 percentile points. Therefore Rob's perception did not correspond to his mother's perception of his behaviors.

In the post-group children's evaluation Rob expressed that he liked the group "a lot" but did not specify any one thing in particular. He said that he learned "a lot" in the group and that he would tell a friend who has problems in his or her family about the group. In the post-group mother's evaluation of the children's group Juli expressed that she liked the group for Rob because it "made him feel good about himself and that he belonged" and "he felt everyone liked him". When asked if she noticed any change in Rob as a result of participation in the group she answered "no". She felt that she received "a lot" of information about what Rob learned in the children's group and thought that the group helped him somewhat. One suggestion made by Juli was to ensure that all group members attend regularly.

Rob entered the group as a very confident child, and he played the role of leader for the majority of the group. Rob was enthusiastic and eager throughout the course of the group. He contributed to conversations and offered answers to questions, he demonstrated his athletic ability during games, he was very funny and made the rest of the group laugh, and he appeared positive and confident throughout many of the

sessions. Rob had a lot of influence on the other children in the group which at times proved positive, such as when he made an effort to include Travis in his relationship with Jeremy. At other times, his powerful position in the group was negative, such as when he attended the group in an unfriendly mood, which affected the rest of the group members. As the group progressed, instead of becoming more comfortable with the group and with the content of the sessions, Rob became more defiant and hostile, and he became disinterested in the content of the sessions. As the group came to an end Rob appeared to have regressed instead of progressed.

During the follow-up meeting Juli expressed her continued frustration with Rob's behaviors, and explained that the behavior problems that he presented with at the time of intake were continuing and increasing. Following the meeting with Juli, it became apparent that Rob was at risk of removal from the home due to Juli's frustration with him and his behaviors. She expressed her desire to call Child and Family Services on a few occasions due to his behaviors. A systems meeting was scheduled and included all of the supports that were in place for Juli at the time. Many issues were still evident for this family upon termination, and EHCC provided them with continued support following the end of group.

Summary

At the time of intake, as the research suggested, the child witnesses of domestic violence presented with a myriad of symptoms to varying degrees. Parents who requested counseling for their children expressed concerns regarding externalizing symptoms such as being controlling with family members and friends, exhibiting aggressive behaviors at home and at school, having feelings of anger, having

outbursts and fits of rage, and performing violent behaviors. Internalizing symptoms were also reported including being withdrawn, not liking to talk about their feelings, and feeling emotional and sensitive. The scores on the CBCL at the pre-test varied. Brooke and Rob scored in the clinical range for internalizing, externalizing, and total score, and Jeremy scored in the clinical range for internalizing only, with his total score and his score for externalizing in the normal range. The post-tests showed many positive changes. Jeremy's external score and his total score decreased, and all of Brooke's scores including internalizing, externalizing, and total score decreased. In addition to theses positive changes, there were also some aspects that remained the same at post-test. For example, Jeremy's internalizing score remained the same at post-test and Rob's scores at post-test, although not directly comparable to the pre-test, remained in the clinical range.

The scores on the Piers-Harris at pre-test indicated varying levels of self-perception on behalf of the children. Jeremy and Rob had comparably low scores, falling at or below the 16th percentile, and Brooke had a higher score at the 88th percentile. The post-test showed modest and significant increases, with Jeremy and Rob increasing their total T-scores by 7 and 72 percentile points respectively. The post-test showed a decrease as well, with Brooke's total T-score decreasing 4 percentile points. The changes in the scores may be attributed to the children's participation in the group, their parent's participation in the group, the multifamily component of the group, external factors extraneous to the group, or a combination thereof.

The written and verbal feedback received from the children and their mothers indicated that the group was beneficial for all members. They all responded positively to their inclusion in the group. Although success as defined by the clients was not achieved in all cases, all families expressed happiness with their inclusion in the group. From my perspective as a group facilitator, this group of children enabled me to see both successful and unsuccessful endings in terms of the purpose of the group. From this experience it was clear that the same intervention impacts different children and families in different ways. In two cases I witnessed a positive change in the dynamics between mother and child, and saw the emergence of a positive relationship between the two (Anne and Brooke; Jane and Jeremy). It was amazing to see a relationship between mother and child switch from one potentially destructive path to a much more positive and healthy path. It appeared that this type of group intervention was a good fit with these families. They took advantage of all that was offered within the groups, and they gained maximum benefit from them. Having the experience of witnessing the difference in the families before and after treatment allowed me to see the benefits and importance of group work with this population.

The experiences of other families in the group were not as successful, such as with Juli and Rob, and Marsha and Travis. For different reasons, they did not seem to benefit as much from the group atmosphere as the other families, and they left the group without any major positive changes. These contrasting outcomes demonstrated that group work impacts each child and family differently, and that while some experience success and fulfill their goals, others do not.

Because of the heterogeneous nature of this population there are many unique children, all of whom will emerge differently from group therapy. For example, children who are experiencing more intense symptoms may not benefit from group, as the group may not be able to offer the extent of therapy they require (Hughes & Luke, 1998). This appeared to be the case for Travis. An introverted child who feels uncomfortable in a group setting would not benefit from a group as he or she would not feel safe to make any progress. The experience of children whose mothers are not able to progress in the mother's group would be impacted as well, which may have been the case for Rob and Juli. The age or sex of the child, their resiliency level, and any risk or protective factors in place for the child would also change the individual experience of the group. Therefore, not all child witnesses to domestic violence will benefit from a group intervention as outlined in this practicum. Success depends upon the individuals themselves, not the category that they are in.

Group Member Profiles for the Children's Group

The follow-up worker at a local women's shelter had been working on an individual basis with all but one (Doris) of the mothers of children referred to this group, regarding the abusive relationships that they had been in upon their entrance to the shelter. Throughout her work with the women, one of the common themes discussed was the women's struggle with their children's behaviors. When the worker suggested to the women that their children might benefit from a group for children who had been exposed to domestic violence, they all agreed that it was a good idea. The worker facilitated a support group for the mothers which ran parallel to the children's group. To follow is an overview of each child in the group.

Ben

Ben is an eight-year-old boy. At the time of intake, the worker at the shelter had been seeing Ben's mother Barb for one year regarding issues surrounding the abusive relationship that she left. Barb is a twenty-nine year old single parent living with her three children who range in age from two to eight years. She has full custody of the three children. Ben does not have regular contact with his father. Barb agreed that Ben would benefit from a therapy group for children who had witnessed family violence, as she described that he had witnessed physical and verbal abuse between Barb's mother and step-dad on many occasions, and between Barb and a few of her partners. In addition, Barb mentioned that Ben had been the victim of physical and verbal abuse by her last partner. At the time of intake, Barb expressed struggling with many of Ben's behaviors including "fits of rage", and physical and verbal arguments that he engaged in with his sister, Brianna (6). Barb also explained that Ben had talked about suicide in the past, he had a difficult time keeping friends, and there was frequent conflict with the friends that he had. Ben was on a waiting list to be assessed by a psychiatrist for a number of possible diagnoses at the time of intake including Asperger's syndrome, Autism, Obsessive Compulsive Disorder, Oppositional Defiant Disorder, and Attention Deficit Disorder. Ben participated in all of the eleven group sessions.

Tom

Tom is an eleven-year-old boy. At the time of intake, the worker at the shelter had been seeing Sandy, Tom's mother, on an individual basis for approximately two years regarding the physically, sexually, and verbally abusive relationship that she had been

in for a number of years with the children's father. Sandy is a forty-year-old single parent living with her three children who range in age from five to eleven years. She has joint custody of the children with primary care and control. The children see their dad on regular weekly and weekend visits. Sandy expressed interest in having Tom take part in the children's group because of her concern over his maladaptive behaviors, which she felt may have been a result of the fighting he had seen between his parents over the years. She described Tom as angry, having mixed-up feelings, and said that he often got into trouble at school. Prior to inclusion in this group Tom had taken part in two groups, both for children of divorce. Tom took part in the children's group and he attended eight of the eleven sessions.

Jake

Jake is a ten-year-old boy. Jake and his mother Doris were referred to EHCC through their Child and Family Services social worker. Doris was seeing a follow-up worker at a shelter for individual counseling. Doris is a thirty-seven-year-old woman who lives with her three sons who range in age from five to ten years. She also has a daughter who lives away from the home. Doris is separated from her husband, and the children do not see their father. Doris described experiencing verbal and emotional abuse from her husband throughout their eleven-year marriage. She also described yelling arguments that often occurred between her husband and her daughter and she explained one violent incident that occurred between her husband and her daughter. She expressed concern about the impact of the violent atmosphere on her son Jake. She was concerned about Jake's aggressive behaviors, his frequent suspensions from school for fighting, and his inability to concentrate at school. Jake

was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and had been taking Ritalin for a year at the time of intake. Jake attended ten of the eleven sessions of the children's group.

Mark

Mark is a nine-year-old boy. At the time of intake the follow-up worker had been seeing Mark's mother Gwen regarding the physically and verbally abusive relationship that she was in with her partner for a number of years. Gwen is a thirty-five-year-old single parent of two children ages nine and fourteen. Mark's father has access to Mark, however there are few visits. Gwen described Mark as being angry, having a short attention span, having a hard time concentrating, and having difficulty expressing his feelings. Mark attended nine of the eleven sessions.

Naomi

Naomi is a ten-year-old girl. At the time of intake, the follow-up worker had been seeing Naomi's mother Sheena for a short period of time regarding the long-term physically and verbally abusive relationship that she recently ended. Sheena is a thirty-nine year old single parent, and Naomi is her only child. Naomi sees her father on the weekends. According to Sheena at the time of intake, Naomi had tantrums and argued with her, she did not listen, and she had mixed-up feelings regarding her parents' separation. In addition, Sheena described physical fights instigated by Naomi towards her; one situation was described where Naomi threatened Sheena's partner with a knife. Naomi attended three sessions, however due to low attendance and personal issues that Sheena was dealing with at the time, it was decided that Sheena and Naomi would not continue to attend group. A follow-up meeting was

scheduled with Naomi to discuss her experience of group, to outline her strengths, and to have formal closure. Naomi expressed her happiness with her inclusion in the group, and expressed an interest in returning to EHCC for further treatment.

Analysis of the Group Intervention: Children's Group

To follow is an overview of the stages of group development as outlined by Siepker and Kandaras (1985), with an analysis of how the children's group passed through the stages. Comparisons to the multifamily group will also be incorporated into the analysis, as the two groups co-existed, and followed similar outlines. The children's group was influenced by a developmental psychopathology framework in addition to social learning theory, attachment theory, and trauma theory, just as the multifamily group was.

Stage I: Preparation

Initially, recruitment for the children's group was difficult, as there were no families who expressed interest in a group for child witnesses of domestic violence. There were families recruited for the multifamily group where the mothers played an integral part in the therapy process, however there did not appear to be interest in a children's group alone. After a month of failed attempts to obtain children for the group, a new strategy was implemented which incorporated a local women's shelter in the recruitment process. After a meeting with the shelter's follow-up worker seven children were recruited for the children's group. Following this meeting the group came together within three weeks.

During the first intake scheduled with the mothers, they all appeared eager to have an intervention in place for their children, as they described their children adding a

great deal to their level of stress. All of the mothers were getting ready to attend their own group for battered women when the idea of a children's group was proposed to them. They all appeared enthusiastic about the idea of a group for their children that dealt with issues surrounding family violence.

During the second meeting with both the mothers and their children, breaking the secret was extremely difficult for some families, and easier for others. There was one case where the child was very anxious and visibly uncomfortable, and he did not want to discuss the topic at all. When his mother was turned to for some assistance in remembering an incident of family violence, she also was uncomfortable and did not offer any help. After a few interruptions including a bathroom break, the child abruptly blurted out one incident that he recalled. It was a very difficult process, but an important one so that the child knew that he was able to talk about the subject in the group, which would therefore allow him to make progress in the group. All of the other children appeared slightly uncomfortable discussing the topic area, however their mothers helped to put them at ease and helped to encourage them to discuss some fighting they had seen or heard. Once all of the intake interviews were completed, the group was ready to begin.

The intake and assessment process for this group of women and children was slightly different from that of the multifamily group. Each of the women had been engaged in individual therapy regarding their abusive relationships for varied amounts of time, the focus of which was on their own personal healing. The prospect of including their children in the healing process was proposed to them as an addition to their own therapy. The mothers in the multifamily group on the other hand, sought

out the help of EHCC for the purpose of helping their children. The difference in the motivations behind having their children attend a therapy group, and the level of inclusion in their child's progress, would prove to be an important factor in their children's success.

Stage II: Exploration

The beginning of this group incorporated the same components as were seen in the multifamily group. The children were introduced to the different areas of the room including the check-in circle, craft corner, and the game area, they were shown the agenda, the issue of confidentiality was explained through Secret Sammy, and the group brainstormed for group rules. In this group, as in the multifamily group, the children relied on the structure, as they sought out the agenda as soon as they entered each session and made sure that all of the items on the list were covered. In addition, the children liked to play with Secret Sammy and used him as a distraction during group. They would poke at him, pull at his ears and other appendages, and would fight over who would hold him. The manner in which the children were treating Secret Sammy was used as an example of appropriate and inappropriate ways to treat others. It was explained that Secret Sammy was upset that his private space was being invaded and that the children were not being respectful of him. The children were told that Secret Sammy still wanted to hear their stories, but he wanted to stay in his box where he was safe and secure. On occasion, if a child asked to play with him or hold him, they were told that they could as long as they treated him with respect. The children responded well to this, and anytime a child was acting disrespectfully towards Sammy, another would usually point it out to a facilitator.

During the exploration phase the group emerged as a rambunctious one. Three boys in the group, Ben, Jake, and Mark were at the core of the disorderly behavior. Ben displayed behavior that was immature and anxious, Mark was uncontrollably restless, and Jake was very aggressive towards the other group members. Two other group members, Tom and Naomi were quiet and respected the group rules. A potential explanation for the rambunctious behaviors that the children were exhibiting was anxiety, which was likely resulting from the new and uncertain environment they were introduced to (Lampel, 1985). Throughout the group there were many times when the content of the session had to be altered, as the children's moods dictated the type of activities that took place. For example, when the children were extremely rambunctious, reading a book was not an effective activity. When this occurred, some activities had to be omitted or put off until later on in the session, and replaced with activities that were more appropriate for the demeanor of the group.

Another factor that may have contributed to their heightened anxiety levels was the length of the session. The session was two hours in length, and although some of the children's behaviors were unruly throughout the entire session, these behaviors escalated during the last half-hour of the group. The children's portion of the multifamily group lasted 75 minutes in length, whereas this children's group was 120 minutes in length. During the last half-hour of the group the room became very hot and stuffy and the children became increasingly loud and restless. As a result of this extended amount of time, more games had to be incorporated into the content of the group compared to the multifamily group in order to keep the children occupied. Also, the amount of therapeutic content was slightly increased in the children's group

compared to the multifamily group, with the addition of one or two extra therapeutic interventions each session. Because the mothers were meeting at the same time as the children, we had to keep the children occupied for the full two hours. Initially we attempted to conduct a ninety-minute therapeutic group with the last half-hour left over for a movie or free time. However, the children were restless and hot and this did not work. Therefore, we extended the group to last the full two hours, dispersing the therapeutic content throughout. We brainstormed different ways to shorten the group, however because we had committed a two-hour group to the mothers who had expressed their pleasure in this time away from their children, we did not change the format.

One problem that emerged at the beginning of the group, was Jake's aggressive behavior towards the other group members. Jake bullied the others in the group by pushing, pulling, hitting, intimidating, and throwing their personal belongings around. This problem emerged in the first session, and because the multifamily group was also dealing with a child who was exhibiting aggressive behaviors, a few techniques had already been identified which were then implemented in the children's group as well. Two techniques included positive reinforcement for good behaviors, and positive reinforcement for expressing your feelings to another child in the group. Both of these techniques flowed from social learning theory (Bandura, 1977). In response to positive reinforcement for good behavior, Jake appeared to appreciate the rewards that he received as a result of behaving and following the rules, and at times he would emphasize or exaggerate good behavior in anticipation of a reward. For example one session he asked politely if he could leave the room and get a drink,

whereas his usual behavior would be to leave without asking. These behaviors were unexpected but welcomed and rewarded not only with candy, but with verbal approval and praise as well.

The second technique, positive reinforcement for expressing your feelings, also appeared to be effective. Although Jake did not use this technique for expressing his feelings to other children, the other children were able to express themselves to Jake in a safe and secure environment, and Jake was able to hear how his behaviors were affecting the others. Information from trauma theory suggests that providing a safe environment is important as children may be experiencing increased arousal as a result of the violence they witnessed (Levendosky et al., 2002). During one session after Jake had pushed Ben, Ben was asked how he was feeling about being pushed. Ben turned to Jake and said in a loud voice; "I don't like it when you push me!" Jake seemed surprised by the comment, and it may have helped him to understand how his actions made others feel. In addition, Ben appeared to be empowered by his comment. This experience may not have been possible in an external environment that was not secure. Both of these positive reinforcement techniques appeared to work for Jake, but only for a short time. He reverted back to his aggressive behaviors, which continued to be a problem for the group.

Another technique introduced in the children's group, which was being used within the multifamily group and was showing to be somewhat effective, was 1-2-3-magic. This technique was introduced to this group of children as a possible technique to deal with their rambunctious behaviors, and to control Jake's aggressive behaviors. This technique did not prove to be effective with Jake, as his behaviors

were dangerous to the others in the group, and counting to three was not an option. Three was reached right away, and a time-out was given. This technique was not needed with any of the other children, as their behaviors did not require more than a verbal reminder to follow the rules.

An issue emerged at the beginning stage of the group which made it difficult for the children to feel safe and to move onto the next stage of group development. Jake's aggressive behaviors had become a concern for two of the mothers as their children had expressed that his behaviors scared them, and all of the children expressed to the facilitators that they were afraid of Jake. In this unsafe environment, the children were not able to feel comfortable, and continued to exhibit very anxious behaviors. An example of how Jake's aggressive behaviors impacted the children was seen in Tom. Tom was a victim to some of Jake's aggressive behaviors, such as pushing, pulling, and name-calling, and Tom was extremely quiet and withdrawn during the first few sessions. Tom's mother Sandy expressed to me that Tom was scared of Jake, and that the aggressive behaviors that Tom was being exposed to in the group were the behaviors that Sandy had tried so hard to eliminate from his life. She expressed that she did not want Tom in the group if he was exposed to these aggressive behaviors. She decided to give the group one more try to see if Tom wanted to continue with group or leave group. When Tom came for the last time to give the group a try, Jake was not present. Tom's behaviors were much different than in any of the previous sessions that he attended. He was much more outgoing, he contributed to conversations, he talked and interacted with the other group members, and he volunteered to answer questions. Although there are many factors that may

have contributed to Tom's change of behavior, the absence of Jake's threatening behaviors may have contributed to his ability to be more at ease in the atmosphere of the group.

A meeting was organized to include Jake and his mother Doris as well as the facilitator of the mother's group, and myself. During the meeting Jake's aggressive behaviors were addressed and a behavior plan was implemented for him. Jake was told that his aggressive behaviors were inappropriate and were not acceptable in the group. In future groups Jake agreed to express his feelings through appropriate words instead of through physical means, name calling, or intimidation. Jake suggested alternatives to his aggressive behaviors such as using his words or talking to a facilitator. Jake was told that we wanted him to be a part of the group and that we enjoyed having him in the group, but that his aggressive behaviors made the group unsafe. He was told that the next time he initiated inappropriate physical contact with another child, he would be permanently removed from the group.

A discussion about the inappropriate nature of aggressive behavior occurred with all of the children in the group. They were told that the group was meant to be a safe place where children could come and feel comfortable sharing their feelings and stories about their experiences with family violence. Because all of the children had expressed their fears of Jake to either the facilitator or to their mothers, I felt that it was necessary to let them all know that the necessary steps had been taken to ensure that they could come to group and feel safe. According to Brandler and Roman (1991) in order for children to feel comfortable in the group setting, the facilitator must form trusting relationships with them, and maintain a safe environment for them

to attend each week. I felt that by letting the children know what was going on with Jake, regarding the fact that we were not going to accept his aggressive behaviors anymore, I helped them to feel more comfortable to return to group each week.

At around the same time that Jake was having a difficult time controlling his aggressive behaviors within the group, Doris revealed that Jake had made a disclosure to her. She said that Jake had seen his sister and father in bed together on a few occasions. Jake's father was being charged, Jake had to give a police statement, and the family was in trouble financially which led to the family having to move out of their home. Therefore, Jake was in the middle of a crisis at home, which most likely contributed to his behaviors in the group. A developmental psychopathology model suggests that more risk factors present for a child increases the chance of developing psychopathology or behavioral difficulties (Sameroff, 2000). This appeared to be the case for Jake as he was facing many new problems at home, and was acting out behaviorally in the group.

During the meeting just mentioned that addressed Jake's aggressive behaviors, we also addressed the disclosure. We told Jake that it was very brave of him to tell his mom, that we were very proud of him, and that he had done the right thing. Jake expressed feelings of guilt regarding his disclosure and described worry that his family members would be mad at him. Following the meeting Jake did extremely well in the context of the group in his attempts at controlling his aggressive behaviors, considering the external circumstances.

According to Lampel (1985) while some parents may see positive changes in their children as a result of their participation in the group, some parents may notice that

their children's maladaptive behaviors have increased. This was the case for Ben's mother Barb. Around the third session, Barb approached me at the beginning of the group session and said that Ben's behaviors had been getting worse at home and at school. She was concerned and inquired if that was normal. I told her that it was normal for a child to increase their troubling behaviors when they are beginning a therapeutic group that is discussing a topic that they are not used to discussing openly (Lampel, 1985). She appeared comforted by the information and expressed her satisfaction with the group, and her hope that Ben's behaviors would improve as he got more comfortable with the group.

According to Fatout (1996), group members must be free of conflicts that may disrupt the flow of the group and impede their success in order to move onto the next stage of group development. I feel that this was able to occur when Jake's aggressive behaviors were dealt with in an open and honest manner with all members involved.

Session topics in this stage of group were the same as in the multifamily group, including "Getting to Know Each Other", "Feelings" and "Different Kinds of Hurting", as sessions one, two, and three respectively.

Stage III: Anxiety

After Jake's behaviors were addressed in the group, the children appeared to feel more at ease. The facilitators were proactive in predicting Jake's aggressive behaviors, and dealt with them promptly when they occurred. For example, the group's co-facilitator and I stayed close to Jake by sitting beside him in the circle or playing on his team during a game. If he began to move closer to another child in a way that appeared potentially threatening, we would put a hand on his shoulder or say

his name and encourage appropriate behaviors. These actions allowed the children to feel safe. This was evidenced in some of their behaviors towards and around Jake. For example, Ben had been a victim to many of Jake's aggressive behaviors and usually acted cautiously around him. When Jake's behaviors were under more control, Ben seemed to act more carelessly around Jake, not concerned about a physical retaliation. In one session, Ben was spinning around on his knee with his other leg up in the air, and each time he spun his foot came very close to Jake's head. Previously, if Ben had have done that Jake would have stopped him through physical means, however Jake did not respond to Ben's behavior in a physically threatening manner. Although Ben's behavior was inappropriate, it may have indicated that he felt safer in the group and was not afraid of Jake. Ben's behavior was addressed as inappropriate and he stopped.

According to Lewis (1985), during the anxiety stage the children's anxiety levels are high, and they continuously challenge the therapist with their behavior. This was seen mostly in Mark and Ben. Mark was restless within the sessions and appeared nervous and jittery. He made an effort to stay still and participate in the crafts, activities, and conversations however it appeared that he could not stop himself from wandering around the room. Ben engaged in silly behaviors that appeared to be testing the limits. For example, during snack he played with his food and put large amounts of food in his mouth at once. Ben and Mark's behaviors, including avoidance of activities and/or conversations associated with the violence they witnessed and decreased ability to concentrate, may have been signs of stress which may have indicated the presence of PTSD symptoms (Levendsoky et al., 2002).

As suggested by Lewis (1985) a therapist should deal with these behaviors by allowing the children to express their anxieties through activity. Kilpatrick and Williams (1997) also suggest physical challenges as helpful in a group therapy format for children who exhibit PTSD symptoms. One game that facilitated this task was called "Peanut Butter and Jelly". During this game the facilitator said "Peanut butter" in various voices, getting loud and then soft, and the children repeated the word "Jelly" in the same voice. The purpose of the game was twofold. First it allowed the children to escalate their behavior in a controlled manner by having them yell as loud as they could to release some of their anxieties. Coordinating this activity allowed the children to express their anxious feelings through organized activities instead of through maladaptive and disruptive behaviors. Second it taught the children behavioral regulation, as their loud anxiety releasing yells were controlled and de-escalated into soft controlled words. Another activity that helped the children control their anxiety was called newspaper punch. In this activity the children took turns punching a piece of newspaper held by the facilitators. This gave the children a controlled physical outlet for their internal stress and anxiety.

According to Kandaras (1985) when children exhibit anxious behaviors it is the responsibility of the therapist to help the children make the appropriate links between their behaviors and the session topics. I attempted to do this through discussions with the children about why they may be behaving certain ways. For example, during one session when Mark was leaving the circle and wandering around the room, I addressed his behavior to the entire group. I said that sometimes when children feel uncomfortable about a certain topic, they act in different ways to avoid it. Then I

asked Mark if he was wandering around the room because he felt uncomfortable about the group's discussion. I used the same tactic with Ben when he changed the subject during a group conversation, or during the reading of a story. Facing the behavior head on with an honest evaluation of the behavior may have helped the children understand the underlying factors behind their feelings, and to make a connection to their experience of family violence.

The therapist is also responsible for letting the children know that he or she continues to accept them despite their anxious behaviors (Northen, 1969). I attempted this by telling the children that it was okay to feel uncomfortable about the topics that we had been discussing in the group, and that if certain behaviors helped them to feel more comfortable, that was okay.

After attending three sessions, Naomi's mother Sheena decided that attending group was not a good fit for her at that particular time, and she and Naomi stopped attending group. The other children in the group did not appear to be impacted by Naomi's absence. A few children asked why she was not coming anymore and they seemed satisfied with the explanation that I gave them. I told them that Naomi and her mother were not ready to talk about their experience of family violence so they decided to stop coming to group.

As children change as a result of inclusion in the group, their families will be impacted as well (Lewis, 1985). In order to facilitate the child's successful progression through group, the parents must deal with their own anxieties surrounding the changes occurring within their child (Lewis, 1985; Northen, 1969). As mentioned earlier, the focus of the mother's group was on the mother's own

individual healing, and was not meant to be on the children and their healing. In fact the children's group was completely separate. Therefore when it came time for the mothers to adapt to their children's new behaviors and respond to their emerging needs they were not prepared. All of the mothers had an interest in the children's group, and hoped for an improvement in their children's maladaptive behaviors, however they were under the impression that this could be accomplished independent of their inclusion in the children's group. I was also under this impression initially, however with little progress, continued anxious behaviors from the children, and with knowledge of the progress occurring in the multifamily group, I began to sense the importance of the parents in the therapeutic process.

As this revelation was emerging I made an attempt to include the mothers more in their children's experience of group. I made telephone calls to all of them discussing the progress of their children in the group and asked how their children were doing with respect to their presenting problems. I also asked the mothers if they had any questions or concerns regarding the group. All of the mothers appeared very happy with their child's inclusion in the group and did not have any major concerns. Most often if the mothers had any questions or concerns they asked me at the beginning or at the end of the sessions. For example when Ben's mother Barb was concerned about Ben's maladaptive behaviors increasing she approached me prior to a group session. Also, if the children were having problems in the group I addressed the mothers myself, such as when a meeting was organized for Doris and Jake regarding Jake's aggressive behaviors.

This attempt to include the mothers was not enough to impact their involvement with their children. By the time I attempted to include the mothers more in their children's experience of group, they were already engaged in the format of the group as a haven away from their children, and not a time to focus on them. The children's group continued as it was, separate from the mother's group. The key piece of strengthening the attachment between mother and child because of the tendency for child witnesses to domestic violence to have insecure relationships with their mothers, was not possible due to the format that had emerged for this group (Graham-Bermann & Levendosky, 1997). Therefore, an important piece was missing for these families.

Session topics covered in this stage of group included "Fighting in Families" as session four, "Fighting in Families Should Never be a Secret" as session five, and "Mixed-Up Feelings" as session six. All of these session topics were fairly intense, which may have proven difficult for this particular group as was seen by their anxious and avoidant behaviors.

Stage IV: Cohesion

Session topics covered during this stage of group included "Feeling Afraid" as session seven, "Angry Feelings" as session eight, and "Getting Along With Others" as session nine.

The group appeared to become a cohesive unit as the sessions progressed. The children appeared comfortable with the atmosphere of the group and with the other children in the group. They shared stories with the others in the group, they helped to read books and related the experiences of the characters in the book to their own

experiences, and they connected with each other through stories of similar experiences. In addition the children worked together when playing games. For example, during a game entitled Jeopardy where the children answered questions for small prizes of candy, Jake and Ben helped each other out. At one point when Ben did not know the answer to a question, Jake assisted him and the two shared the prize. The children also inquired about anyone missing a session. "Where are they?", "Why aren't they here?", and "Are they coming next week?" were all questions posed by the children. They appeared to be concerned about the status of their fellow group members.

In addition to becoming a cohesive group, the children were also learning the material presented within the sessions and were able to incorporate the material into the games, activities, and crafts. For example, during a game that incorporated information about protection planning followed by questions about the topic, Jake was able to give many wonderful examples of what to do to stay safe in circumstances of family violence. During an activity where the children drew the different kinds of feelings that occurred in their bodies when they were scared, the children were very creative in their depiction of the feelings. For example, Ben drew a butterfly in his stomach on the picture, and Tom and Jake drew large muscles on the biceps to portray how muscles may get tense when you are afraid.

There were many positive indicators that the children were learning the material presented within the sessions and they appeared to be making a connection to the group, however the children were also displaying behaviors that suggested that they continued to be anxious about the topics of the sessions. For example Mark wrapped

himself up in a blanket during stories, he had a difficult time staying on task during crafts, and he often left the circle during discussions. Ben had a difficult time completing some of the activities, he was rambunctious, and he interrupted and changed the subject during conversations. Jake continued to display aggressive tendencies, he wrapped himself up in a blanket sometimes during books, and he was off task at times during crafts. Lastly, Tom was withdrawn at times and he would remove himself from group interaction and conversations. All of these behaviors are consistent with PTSD symptoms (Levendosky et al., 2002).

In addition, instead of improving and progressing as the group proceeded, some group members seemed to be stagnant or regressive. For example, as the sessions progressed Ben was becoming increasingly aggressive, and he became disrespectful of the rules and of the authority of the facilitators. Ben's aggression was shown mainly in throwing objects across the room. Ben threw markers when we were doing crafts and he threw the check-in circle across the room like a frisbee. One time he grabbed an object out of Jake's hands and threw it across the room and another time he threw a jelly bean directly at Mark and it hit him in the face. Ben did not appear to have regret for his actions and he often laughed after he had done something wrong. In Ben's case it appeared that his behaviors were getting worse as the sessions progressed as opposed to getting better. A technique from social learning theory that was applied to control Ben's behaviors was positive reinforcement of good behavior. This worked at times with Ben, however he would soon forget about the potential for reward and would re-engage in rule-breaking behavior. 1-2-3-magic and time-outs

were also used with Ben, neither of which appeared to have much of an impact as his behaviors continued and escalated despite both strategies.

Education of appropriate behaviors occurred within the group throughout the sessions, and many attempts to identify maladaptive thought patterns and teach new more healthy ones occurred through the use of games and activities, the reading of books, engaging in role plays, performing puppet shows, and watching videos. These goals were important according to both social learning theory and trauma theory (Bandura, 1977; Kilpatrick &Williams, 1997). In addition it was important to help all of the group members, specifically Ben and Jake to practice behavioral control. According to Kilpatrick and Wiliams (1997) this is helpful for children who may be experiencing PTSD symptoms.

I phoned Ben's mother Barb regarding my concerns of his escalating behaviors and suggested having a series of individual sessions with her to discuss the potential origins of his behaviors and possible solutions. After the conversation with Barb it was mutually decided that she already had a lot of supports in place to deal with Ben's aggression and to assist her with her parenting techniques, and that adding another support might create confusion and crossed signals. Although Ben's behaviors were escalating within the group, Barb expressed happiness with her ability to deal with his behaviors outside of the group setting. She explained possible reasons for his behavior in the group and said that she continued to work with him on decreasing his maladaptive behaviors.

Jake also showed regression and became aggressive within the group as the group progressed. Jake put a lot of effort into controlling his aggressive behaviors

following the implementation of the behavior plan and although he continually exhibited aggressive tendencies they had decreased a great deal during this time. Following a few sessions of controlled aggressiveness however Jake began to aggress again towards the other group members. He exhibited extremely aggressive behaviors that were not safe for the rest of the group including pushing another child into a corner, using intimidation and name calling, pushing, pulling, hitting, and bullying. Jake did not respond to any of the techniques that were applied to him. During one session Jake had three time-outs, one of which he instigated himself. Following the session Jake expressed that he needed a break from group and suggested that he miss the next session.

By the time Jake was having difficulty controlling his aggression in the group, the group only had three more sessions left including the last session which would be the party. Because of difficult circumstances occurring in Jake's life external to the group it was decided that it was important for Jake to finish the group. A plan was implemented that if Jake began to become aggressive within the group, Linda Perry would be available to work on an individual basis with Jake. This ensured that Jake could leave the group when necessary but would continue to remain a part of the group, and that Jake's mother Doris could continue receiving the much needed support from the mother's group. With this plan intact, Jake did well and did not require removal from the group for the remainder of the sessions.

In addition to Ben and Jake's aggressive behaviors, it appeared that Tom and Mark remained stagnant in terms of the behaviors that they presented with at the beginning of the group. Mark for example continued to appear jittery and nervous, and was

continually restless, moving around the room constantly. Tom remained fairly withdrawn and quiet throughout the sessions. Although it appeared that he had become more comfortable in the middle of the group as he was contributing to conversations and answering questions, his disposition reverted back to shy and withdrawn as the group progressed.

As the group was coming to an end the children appeared to be learning the material and there appeared to be group cohesion, however each child appeared to be struggling with individual behaviors. Many of the behaviors presented by the children were reflective of the behaviors outlined in research as stress related symptoms. For example, "traumatic reexperiencing" (re-enactment through play), "persistent avoidance of the stimuli" (withdrawn), and "increased arousal" (irritability) were all seen in the behaviors of the group members (Lehmann, 1997; Leveldosky et al., 2002, p. 157). The group members' inability to progress may have indicated that they were too traumatized and not ready to deal with these issues.

Another explanation for their inability to progress may have been the lack of connection between the children and their mothers due to poor attachment, which research suggests may be a result of the negative impact that domestic violence has on the functioning of the mother (Semel, 2003). In addition, the format of this group was less ecological than the multifamily group, in that this group only considered the group treatment of the children as the treatment modality independent of other external systems, such as inclusion of the mothers in the therapeutic process. According to a developmental psychopathology framework, it is important to be aware of the many systems that influence a child (Graham-Bermann, 1998).

Lastly, social learning theory may explain the children's inability to progress a result of their beliefs and behaviors being too ingrained to change in a short term group treatment intervention (Bandura, 1977).

Stage V: Termination

When the children were told that the group was coming to an end they appeared unconcerned. Jake expressed that he was glad that he would not have to come back to group anymore, and the others said they were feeling happy that the group was ending. On the second last session a new co-facilitator was in the group as my co-facilitator was absent. This change brought about an increase in the children's active behaviors, however the content of the session was not disrupted too much.

Topics covered in the last sessions included "Families" and "Saying Goodbye". On the last session we took the children on an outing to Ruckers and Dairy Queen. They were all very well behaved and all got along nicely. Jake, who had been to Ruckers many times before, acted like a leader and showed the others which games to play and which not to play. Neither Ben nor Mark had ever been to Ruckers and they listened intently to Jake's advice and followed it. They all acted very respectfully and appeared to have a good time. Upon return to EHCC the children presented their mothers with the picture frames that they had made and they were all very excited and pleased with their mother's reactions. The children were presented with certificates of completion, "I am special" stars, a small present from the facilitators, and a picture frame from their mothers. All of the children appeared proud of themselves, as did their mothers, for having been a part of the group and completing it. The last session went very well.

With respect to evaluating the progress that was made individually for each child, it was determined that Jake, Ben, and Mark were in need of continued therapy following the end of group. Depending on the results from the evaluation measures along with input from the mothers, more specific conclusions would be decided at a follow-up meeting. It was decided that Tom had made sufficient progress in the group and he would be able to maintain his progress outside the group. Although Tom's demeanor was shy and quiet, it appeared that he understood the information presented in the sessions and was able to incorporate it into all of the group activities. He was a bright boy who appeared mature and competent. In addition Tom had taken part in two therapy groups prior to this one, and his mother provided him with an excellent source of support and guidance.

Stage VI: Closure

Follow-up meetings were scheduled with all of the mothers after the group was complete. All of the mothers attended the follow-up session without their children, and all of the meetings were held at EHCC.

Evaluation of the Children's Group Members

The evaluation tools for this group were the same as those administered to the multifamily group including the Piers-Harris Children's Self-Concept Scale (Piers-Harris) and the Child Behavior Checklist (CBCL), both of which were administered at pre-test and post-test to the children and the mothers respectively. In addition, both the children and their mothers were administered the client satisfaction measures which asked their opinion of the children's group. Below is an analysis of the evaluation measures.

Ben

Results from the pre-test and post-test administrations of the Piers-Harris indicated high scores, suggesting that Ben either had high self-esteem, or he was answering the questions as a result of defensiveness or social desirability (Piers, 1984). It appeared to me that Ben was answering the questions both at pre-test and at post-test with the answer that put him in the best light, without paying attention to the truth in the answers. I explained to Ben the importance of telling the truth when answering the questions, and he assured me that he was. However, his answers did not match his behaviors in the group, or my analysis of his self-esteem. All of the scores remained the same from the pre-test to post-test administration except for "popularity" which increased from a T-score of 55 to 61 at post-test. The total scores for both tests were above the 99th percentile (see Table 3).

Results from the pre-test administration of the CBCL indicated five scores that were in the clinical range including "withdrawn/depressed", "somatic complaints", "thought problems", "rule-breaking behavior", and "aggressive behavior", and three scores that were in the borderline clinical range including "anxious/depressed", "social problems", and "attention problems" (see Table 4). Therefore, according to Barb, Ben was having a difficult time functioning in all areas specified by the measure, with aggressive behavior causing the most difficulty. Results from the post-test showed a dramatic change from pre-test to post-test, with all of the scores falling in the normal range. Most notable changes were "rule-breaking behavior" which decreased from a T-score of 74 at pre-test to a T-score of 51 at post-test, and "aggressive behavior" which decreased from a T-score of 83 at pre-test to a T-score

Table 3

Total Scores, Percentiles, and Cluster Scores for the Piers-Harris Scale at Pre-test and Post-test for the Children's Group

	Ben		Tom		Jake		Mark	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Total Score	74	77	51	56	61	65	46	49
Total Percentile	99	99	54	73	86	93	34	46
I. Behavior	66	66	45	54	59	47	54	54
II. Intellectual and School Status	70	70	43	69	50	52	45	59
III. Physical Appearance and Attributes	64	64	46	37	60	65	53	49
IV. Anxiety	69	69	69	63	63	69	41	41
V. Popularity	55	61	61	55	61	69	36	39
VI. Happiness and Satisfaction	63	63	47	52	63	63	63	63

Note. T-scores are reported. Higher total scores indicate a higher self-concept. Scores at or below the 16th percentile are considered clinically significant.

Table 4

T scores for the Child Behavior Checklist at Pre-test and Post-test for the Children's Group

	Ben / Barb		Tom / Sandy		Jake / Doris		Mark / Gwen	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Total Score	76	51	68	71	65	66	65	71
Internalizing	75	57	65	66	57	50	71	68
Externalizing	77	50	66	69	67	72	55	64
I. Anxious / Depressed	67	51	59	62	50	51	69	69
II. Withdrawn / Depressed	73	58	58	58	68	54	66	62
III. Somatic Complaints	78	61	68	68	57	53	70	64
IV. Social Problems	67	53	65	65	65	65	62	70
V. Thought Problems	78	61	64	70	64	54	64	67
VI. Attention Problems	66	53	67	71	69	64	67	79
VII. Rule-Breaking Behavior	74	51	64	67	67	70	53	57
VIII. Aggressive Behavior	83	51	66	68	66	73	53	66

Note. T-scores are reported. All T scores above 63 are in the clinical range, T scores between 60-63 are in the borderline clinical range, and all T scores below 60 are in the normal range.

of 51 at post-test. The total T-score for internalizing behaviors was 75 at pre-test and 57 at post-test, and the total T-score for externalizing behaviors was 77 at pre-test and 50 at post-test. When Barb was presented with the results of this measure she was very excited about the progress that it indicated. She expressed that she was very happy with Ben's behaviors recently and admitted that maintaining a structured environment for Ben and being consistent with rules were starting to show improvements in his behavior.

In the post-group evaluation of the children's group Ben indicated that he liked the group "a lot", especially the games, snack, and craft. He said that he learned "a lot" in the group including "being nice, being responsible, and learning about not hurting people". In the post-group mother's evaluation of the children's group Barb indicated that she felt the group helped Ben "a lot" as it gave him a chance to interact with other children who had been through similar experiences as him. She indicated that she noticed changes in Ben as a result of his inclusion in the group, including that he was more at ease and less angry and upset. Barb also indicated possible changes to be made for future groups. She suggested that she did not receive enough information about the children's group, and she stated that she would like to see the group a bit longer in duration.

Throughout the course of the group Ben displayed many behaviors that suggested that he was uncomfortable with the session topics including wrapping up in a blanket, leaving the circle, interrupting, changing the subject, and playing with an object or making noises as a distraction. Also he appeared to have a difficult time completing some of the activities and taking part in some of the games. As the sessions

progressed I noticed that Ben's anxiety level increased instead of decreased. Instead of appearing to get more comfortable with the group, he appeared to get more anxious, rambunctious, and aggressive. Initially he used his feeling words well, he listened to the facilitators, and he followed the group rules, however near the end of the group he began to listen less to the facilitators, he did not follow the rules as well, and he displayed many rule-breaking behaviors. The behaviors that Ben exhibited in the group suggested that he was not improving as the group progressed, and some of the goals that had been outlined for him at the beginning of the group, including expressing his anger in more appropriate ways, did not appear to be reaching fulfillment.

The behaviors that Ben was exhibiting as the group came to an end did not coincide with the post-group evaluation from Barb on the CBCL or with her verbal accounts of how he was doing. In talking with Barb she was very pleased with Ben's progress at home saying that he was less angry and more at ease, which she said may have been due to some strategies that she had put in place at home (more structure and consistency). Therefore the inconsistency between my evaluation of Ben in the group and his mom's evaluation of him at home, could have been due to the different environments in which he was being evaluated. Ben's behavior in the context of the group could definitely have been different from that in his home. This may indicate that Ben would benefit more from individual counseling or in home family support as opposed to a group therapy format.

Ben appeared to enjoy some of the games and activities and he demonstrated his many skills throughout the course of the group. He was very bright and contributed

to many conversations, he often volunteered to read the books and he was a great reader, he had a great imagination during games, he was creative when doing crafts, and he was funny and made the others in the group laugh. Although his disruptive behaviors escalated as the group progressed, there were also many times where these positive behaviors and traits were evident.

Possible reasons for Ben's escalating behaviors in the group included that this was his first therapeutic experience and this was the first time he had discussed the topic of family violence with anyone. Also, a group environment may not have been the most comfortable for Ben. In addition, Barb mentioned that this was the first time that he had lived with her for a long period of time and he was struggling with this new stability in his life. Barb also mentioned that she was being more consistent when disciplining Ben, which he was also not used to and was having a difficult time coping with.

At the follow-up meeting Barb expressed her joy with Ben, saying that he had improved on many levels including behavior, attitude, and anxiety over the last three months. She stated that he was a new boy and she was very happy with his inclusion in the group. Her comments were consistent with the results of the measures, but contradicted what I had seen in the group context with respect to improvement of Ben's behaviors. It was mutually concluded that the group was a first step for Ben and although he remained anxious throughout the duration of the group and some of his behaviors had escalated as the group progressed, he was at the beginning of a more extensive healing process. His external environment (through Barb's new and effective parenting techniques and her new stability) was one that was supportive and

would help to build and maintain positive behaviors. Barb expressed a desire for additional counseling for Ben as she felt that he continued to have some problems with anxiety. It was agreed that Theraplay (Jernberg, 1979) would be the best option for the family as it would help to strengthen the mother-child bond, and would help to build upon Barb's current parenting tools.

Tom

Results from the pre-test administration of the Piers-Harris showed all of the cluster scale scores above the clinically significant cutoff (16^{th} percentile), with a total T-score of 51 (54^{th} percentile). In the post-test, the cluster scale "physical appearance and attributes" had dropped from a T-score of 46 (35^{th} percentile) into the clinically significant range with a T-score of 37 (11^{th} percentile). The remainder of the cluster scale scores were in the normal range at post-test. The total T-score at post-test had increased to 56 which was at the 73^{rd} percentile. These scores showed an overall increase in self-esteem from pre-test to post-test. However, Tom's self-evaluation of his physical appearance had become more negative at post-test when compared to pre-test.

During both administrations of the Piers-Harris Scale Tom gave his answers in a very monotone and rhythmic voice. During the post-test he answered all of the questions with "no". About a third of the way through the measure, I asked him if he was answering "no" to all of the questions on purpose. He looked embarrassed and said that he was. I asked if we should start over and he said yes. When we started over it appeared that he was answering the questions more accurately. During both administrations he responded to the questions very rapidly, and it appeared that he

was more concerned about finishing the test than answering the questions with accuracy.

Results from the pre-test administration of the CBCL indicated four scores in the borderline clinical range: "somatic complaints", "social problems", "attention problems", and "aggressive behavior". The remainder of the scores were in the normal range. Results from the post-test showed two scores in the clinical range: "thought problems" and "attention problems". The changes that occurred in these two sub-scales were very minimal. The T-score for "thought problems" was a 64 at pre-test and increased to a T-score of 70 at post-test, just reaching the clinical range. The T-score for "attention problems" was a 67 at pre-test and increased to a T-score of 71 at post-test, just reaching the clinical range as well. Four scores were in the borderline clinical range at post-test including "somatic complaints", "social problems", "rule-breaking behavior", and "aggressive behavior". The last two sub-scale scores, "anxious/depressed" and "withdrawn/depressed" were in the normal range. The total T-score for internalizing behaviors was 65 at pre-test and 66 at post-test, and the total T-score for externalizing behaviors was 66 at pre-test and 69 at post-test. The scores for all of the domains as well as the total scores were all in a similar range with no major changes from pre-test to post-test. Therefore, according to Sandy, Tom's functioning in all of the outlined areas of the CBCL / 6-18 remained similar at both pre-test and post-test.

Results from the post-group evaluation of the children's group indicated that Tom liked the group "a lot", most notably the games. In the post-group mother's evaluation of the children's group, Tara expressed that the group helped Tom "a lot".

When asked if she noticed any change in her child as a result of participation in the group she answered "yes" and "no", saying that Tom had been trying very hard to "do everything right" since his participation in the group.

In the follow-up meeting, Sandy expressed an interest in further counseling for Tom due to his continued anger and mixed-up feelings surrounding his mother and father's divorce. Sandy was given positive feedback regarding her strong parenting ethics and her continued efforts to help Tom with his feelings and behaviors. She was told that Tom was doing very well and that continued therapy may not be the answer. This was the third therapy group that Tom had taken part in, and the results of the Piers-Harris and the CBCL did not show any extreme scores to indicate any major issues. In addition Tom appeared to do well in the group overall. He responded well to the content of the sessions and did not exhibit extreme signs of anxiety. For example, during books, puppet shows, or other activities that dealt with serious material Tom usually sat still and listened intently. Although he did not contribute a large amount verbally, he established that he was able to comprehend the material presented in the sessions through his performance in the various crafts and activities. Tom was great at staying focused and completing the tasks that were given in the group.

Sandy responded well to the indications that Tom was doing well and was grateful to hear of his strengths and improvements, however she expressed her continued frustrations with his behaviors. Following the conversation with Sandy in the follow-up meeting it appeared that Tom's anger and mixed-up feelings may have been more a result of the divorce than the violence that he witnessed. Regardless,

Sandy was given the option to put Tom on the wait list at EHCC for individual therapy.

Jake

Scores for the pre-test and post-test administrations of the Piers-Harris scale showed all of the cluster scale scores in the normal range. The score for the "Behavior" scale had decreased from a T-score of 59 (83rd percentile) at the pre-test to a T-score of 47 (42nd percentile) at post-test. Although the score continued to be in a range that was not clinically significant, the decrease was substantial, especially considering that all of the other scores increased or stayed the same from pre-test to post-test. This decreased score may have indicated that Jake had developed some negative feelings about his behavior compared to the pre-test. The total T-score on the pre-test was 61 (86th percentile) and the total T-score on the post-test was 65 (93rd percentile). Jake's self-esteem therefore increased overall, with a more negative self-evaluation regarding his behavior.

Results from the pre-test administration of the CBCL indicated five scores in the borderline clinical range and three scores in the normal range. There were no scores in the clinical range at the pre-test. In the post-test there were two scores in the clinical range including "rule-breaking behavior" and "aggressive behavior", one score in the borderline clinical range, and five scores in the normal range. All of the scores decreased or remained the same between the pre-test and post-test except for "rule-breaking behavior" and "aggressive behavior". Overall, there were minimal changes from pre-test to post-test. These minimal changes were reflected in the total T-scores at pre-test and post-test (65 and 66 respectively). Therefore, the issues that

Jake presented with initially remained at the post-test. One exception was the T-score for "aggressive behavior" which increased from a score in the borderline clinical range (66) to a score in the clinical range (73). The total T-score for the externalizing behaviors was 67 at pre-test and 72 at post-test. This revealed that Jake had a difficult time managing his externalizing behaviors, and his difficulties continued and increased upon the administration of the post-test. The total T-score for internalizing behaviors was 57 at pre-test and 50 at post-test. Therefore, internalizing behaviors were not a problem area for Jake.

Results from the post-group children's evaluation indicated that Jake liked the group "a lot" including the games, snack, and art. He expressed that the group helped him to learn "about fighting in families, and that it is wrong" and the group helped him to control his anger. In the post-group mother's evaluation of the children's group Jake's mother Doris expressed that she did not notice any change in Jake as a result of participation in the group. She thought that the group helped him "somewhat" where he learned that it is not right to hurt people and she expressed that she enjoyed the time to herself when Jake was in the group.

In the follow-up meeting with Doris she expressed her frustration with Jake's continued and escalating aggressive behaviors. The results of the CBCL supported these frustrations with an increased score for the "aggressive behavior" scale at the post-test. In addition, the score on the "behavior" cluster scale on the Piers-Harris scale had decreased from pre-test to post-test, indicating that Jake evaluated his behavior more negatively at the post-test. Therefore, the increase in Jake's aggressive behaviors was evident to both Jake and Doris.

Within the context of the group Jake had a difficult time controlling his aggressive behaviors from the beginning. Around session number four Jake's aggression had reached a high level that was unacceptable within the group. This was when Jake made the disclosure to his mother, and when the meeting was organized to make a behavior plan for Jake's aggressive behaviors. Following the meeting Jake did extremely well in the context of the group in his attempts at controlling his aggressive behaviors, considering the external circumstances. However, after two sessions Jake reverted back to his aggressive tendencies, which continued until the end of the group.

It appeared that Jake was able to understand the content of the group, which was seen in his contributions to games and activities. In addition, he was very bright, he had a great memory, he was creative, and he got along well with the others in the group when he was not aggressing towards them. However, Jake's external environment became extremely unstable following his disclosure, which made it difficult to make any progress in the group. In addition, Doris was dealing with many issues of her own and was not in a position to support Jake to the extent that he required.

At the follow-up meeting, Doris was asked her opinion with respect to additional counseling for Jake considering her struggles with his behaviors. Although Doris was slightly reluctant to enroll Jake in additional counseling as he had told her he did not want further counseling, she mentioned to her social worker that she would like Jake to be referred to EHCC for individual therapy.

Mark

Results from the pre-test administration of the Piers-Harris indicated one cluster scale score that was in the clinically significant range, (i.e., below the 16th percentile), which was "popularity" with a T-score of 36 (9th percentile). The remainder of the scores were in the non-clinical range, however the score for "anxiety" was very close to the clinically significant range with a T-score of 41 at the 19th percentile. The total T-score for the pre-test was 46 which was at the 34th percentile. In the post-test the score for "popularity" remained in the clinically significant range with a T-score of 39 (15th percentile), and the score for "anxiety" remained the same as well with a T-score of 41 in the 19th percentile. The rest of the cluster scale scores at post-test were in the normal range, and the total T-score for the post-test was 49 which was at the 46th percentile. Overall, Mark's level self-esteem was similar at both pre-test and post-test, and he continued to feel the least confident about his level of anxiety and his popularity.

Results from the pre-test administration of the CBCL indicated one score in the clinical range ("somatic complaints"), three scores in the borderline clinical range ("withdrawn/depressed", "anxious/depressed", and "attention problems"), and the remaining four scores in the normal range. Results for the post-test showed two scores in the clinical range ("social problems" and "attention problems"), three scores in the borderline clinical range ("anxious/depressed", "thought problems", and "aggressive behavior"), and the remaining three scores in the normal range. The T-score for internalizing behaviors was 71 at pre-test and 68 at post-test. Therefore, according to Gwen, Mark's internalizing behaviors decreased slightly. For example,

"somatic complaints" decreased from a clinical range T-score of 70 at the pre-test to a normal range T-score of 64 at the post-test. The T-score for externalizing behaviors was 55 at pre-test and 64 at post-test. This increase was seen in the significant changes from pre-test to post-test in the areas of "social problems" which increased from a normal range T-score of 62 at the pre-test to a clinical range T-score of 70 at the post-test, "attention problems" which increased from a borderline clinical range T-score of 67 at the pre-test to a clinical range T-score of 79 at the post-test, and "aggressive behavior" which increased from a normal range T-score of 53 at the pre-test to a borderline clinical range T-score of 66 at the post-test. Gwen therefore found that following the group Mark had developed a higher degree of difficulty in the areas of social problems, attention problems, and aggressive behavior. The total T-score increased from 65 to 71, indicating an increased level of difficulty for Mark overall.

The post-test children's evaluation of the group indicated that Mark liked the group "a lot" including check-in, games, and the books. Mark said that he did not like the snack portion of the group. In the post-group mother's evaluation of the children's group Mark's mother Gwen expressed that she felt the group helped Mark "a little" by helping him to become more "expressive". Gwen suggested that in future group the mothers should be informed more about what happens in the children's group including the meaning behind some of the activities.

In the group Mark continued to exhibit restless and anxious behaviors from the beginning to the end. He would often leave the circle when discussions were initiated, he had a difficult time staying focused on crafts and activities, and he often used the blankets for comfort during stories or puppet shows. These behaviors did

not appear to dissipate at all as the group progressed. In addition to his anxious behaviors Mark appeared to have a difficult time befriending the other group members. He made attempts that were unsuccessful. For example during one incident he approached another child and said "I like you…do you like me?" which did not get a response. Mark was also a victim to some bullying from the other children. Results from the Piers-Harris Scale showed that Mark had a low perception of himself with respect to popularity and his level of anxiety.

In the follow-up meeting, Gwen indicated that Mark had become more emotional and defiant since the group and she requested further counseling for him. It was revealed throughout the course of the group by Gwen that she continued to have contact with her ex-partner who continued to exhibit verbally abusive behaviors towards her in front of Mark. Gwen was told that it was not beneficial or optimal for children to take part in therapy for exposure to family violence when they continued to be exposed to family violence, because this puts the child in an uncomfortable and unfair position. She was told that she should call EHCC for a referral for additional counseling for Mark when she could further remove her ex-partner from her life.

Summary

The children who made up the children's group presented with a variety of symptoms to varying degrees, as was the case in the multifamily group. Externalizing symptoms such as aggression, physical and verbal arguments with siblings and friends, and suspensions from school for fighting were reported, and internalizing symptoms such as having mixed-up feelings, talking about suicide, and having difficulty expressing feelings were also included. The scores on the CBCL at

the pre-test indicated varying levels of internalizing and externalizing problems. The post-tests showed both modest and significant positive changes as well as negative changes. Therefore, there appeared to be a mixture of feelings from the mothers with respect to their children's presenting issues as scored on the CBCL. Some found the changes to be dramatic, either in a positive or a negative way, while others found little or no change in their child's behavior. Pre-test scores from the Piers-Harris Scale showed a wide range of scores indicating many different levels of self-esteem among the children. The post-test showed modest improvements for all of the children. Because of the many extraneous variables that were present while the children were taking part in the group, any changes in the scores must be interpreted with caution and cannot be contributed solely to their participation in the group.

Information from the client satisfaction data and the follow-up interviews indicated that all of the mothers of the children who were involved in the group requested further treatment for their children. They all expressed pleasure with their children's inclusion in the group, however for many of the families this group was the beginning of a longer treatment process.

As the facilitator of this group I learned a great deal. My learning came from my observations of this group alone as well as the comparisons that I was able to make with the multifamily group. As the two groups progressed, similar scenarios arose for both. Both groups had a member who had a difficult time controlling his aggressive behaviors, and both groups had to deal with the loss of a group member. Dealing with these issues in one group helped me to handle them in the other. Although the groups presented with similar issues (all were child witnesses to domestic violence)

and revealed similar scenarios, there were important differences between the groups as well. The personalities of the children were different for example, which changed the atmosphere of the group altogether, and the group dynamics were different. Most importantly, I noticed that there appeared to be less progression towards outlined goals in the children's group when compared to the multifamily group. Also as the groups came to an end, all of the mothers of the children in the children's group requested continued treatment for their children. From their comments it appeared that they viewed their children and their children's behaviors as the main problem and the reason for continued treatment. On the other hand the mothers of the multifamily group who fulfilled their goals successfully were able to realize their vital role in their children's progress.

From this experience, I believe that an important factor in creating a more successful outcome for the multifamily group was the heightened inclusion of the mothers in the therapeutic process. The mothers in the children's group were included in the therapeutic process, but not to the extent of the mothers in the multifamily group. The learning and progress that occurred in the mother's group portion of the multifamily group, in terms of understanding their child's experience and gaining empathy for their child, appeared to contribute to a more successful outcome for the children in the multifamily group. In addition, the work that was accomplished in the multifamily portion of the group when the mothers and children came together was important to build the attachment between mother and child.

In comparison, the premise of the group attended by the mothers of the children's group was different from that of the multifamily group. It focused less on their

children's experience of family violence, and provided more of a supportive environment for the mothers to discuss personal issues. Although this basis was likely helpful for the women and their own personal struggles, and they were probably able to make their own personal progress, this outline did not provide the women with the opportunity to understand their children and therefore help them to progress. As suggested by research, children will not progress in the group unless progress has been made by their parent (Lewis, 1985; Northen, 1969). In addition, the opportunity to build and strengthen the attachment between mother and child is vital according to attachment theory as mother-child dyads from families of violence often have poor attachments (Graham-Bermann & Levendosky, 1997). These poor attachments are sometimes due to the impact that domestic violence has on the functioning of the mother and her ability to parent effectively (Levendosky & Graham-Bermann, 1998). This important piece was missing from the children's group which may have impacted the success of the children in the group.

Chapter V Practice and Learning Themes

Method of Intervention

Benefits of Group Therapy

Many of the benefits of group interventions that have been outlined in the literature and which were reviewed earlier, were evident within the context of the groups that made up this practicum. First, the groups allowed the children to acquire knowledge and social skills necessary for their healthy development. The groups provided the children with education about family violence and taught them coping strategies and appropriate means of behaving. In addition the children were given the opportunity each week to apply what they had learned in a safe and secure environment and in the company of peers. This may not have been as effective in an external environment or in another non-group treatment modality. As an example, when Ben told Jake how he was feeling about being pushed, Ben provided the group with a socially appropriate reaction to aggressive behaviors, which resulted in a positive outcome (Jake apologized), and Ben gained self-confidence through his expression of feelings. Jake was able to learn about how his behaviors impacted others, he witnessed an appropriate and effective reaction from Ben, and he reacted in an appropriate manner, by apologizing instead of behaving aggressively. In an external and unsafe environment Ben may not have had the courage to say something to Jake, and Jake may have been aggressive towards Ben. In a non-group treatment modality this interaction between peers and acquisition of social skills would not be possible.

Another benefit of the group that was evident was the opportunity for social interaction between the children. The group allowed the children to fulfil their intrinsic need for interaction and association with peers. The children's need for acceptance and belonging was seen when they mimicked each other's silly behaviors in order to fit in. The group was also beneficial in that it allowed the children to impact each other in ways that a facilitator could not do. This was witnessed when Brooke provided the group with insightful support and information about still being a family even though their dads were gone, which according to research would not have had the same impact if heard from a facilitator (Coolidge & Frank, 1984; Glass & Thompson, 2000). The group also gave the children a chance to break the secret of family violence and allowed them to realize that they were not alone.

Explanatory Theories as a Guide for Therapy

A developmental psychopathology framework helped to guide this practicum. This framework added to my understanding of child witnesses of domestic violence by explaining the direct and indirect impacts upon child witnesses, the risk and protective factors that are present for child witnesses, and the moderators that contribute to the functioning of child witnesses. Through this information I was informed about the heterogeneous nature of this population and hence their differing needs. The risk factors that impact child witnesses as outlined in a developmental psychopathology framework were further indicated in the three theories that I chose to guide the intervention. Social learning theory, trauma theory and attachment theory all helped to highlight the different risks that child witnesses are exposed to.

According to Bandura's social learning theory (1977) children learn attitudes and behaviors from their primary role models, their parents. For a child living in a family with family violence, the child may be at risk for developing unhealthy thoughts and behaviors as they are reinforced for inappropriate behaviors by their parents. Through their inclusion in the therapeutic group the children were introduced to a new environment and new role models, where they were exposed to positive interactions, behaviors, and attitudes, which they could witness and learn from. In addition, the facilitators employed reinforcement with the children, where they were rewarded for good behavior and were given consequences for poor behavior. Also, psychoeducation, cognitive rehearsal and cognitive restructuring were utilized with the children in sessions with topics such as breaking the secret of family violence and self-blame and feelings of responsibility for violence in the family. Changing their thoughts may have helped to change their behaviors as well.

According to trauma theory, children who live in a family characterized by family violence are at risk of being traumatized. The symptoms indicative of trauma include "traumatic reexpariencing of the trauma", "persistent avoidance of the stimuli that are associated with the trauma", and "increased arousal following the traumatic event" (Levendosky et al., 2002, p. 157). The internalizing and externalizing symptoms that child witnesses typically exhibit therefore are according to trauma theory a result of the child being traumatized by the violence they witnessed. Interventions based on this theory that were covered in this group intervention included the provision of a safe and secure environment and the chance for the children to practice new more healthy behaviors. This was important especially since the children were

experiencing trauma. The identification and restructuring of negative thought patterns and addressing the sense of isolation were also predominant themes throughout the group which were outlined by Kilpatrick and Williams (1997) as important for traumatized child witnesses to domestic violence.

According to attachment theory children are at risk of developing difficulties when they have poorly formed attachments with their mothers (Graham-Bermann & Levendosky, 1997). These poor attachments result from the direct impact that domestic violence has on maternal psychological functioning which indirectly impacts parenting (Levendosky et al., 2003). An important component included in the multifamily group included the multifamily portion of the group. During this portion, mothers and children came together and engaged in therapeutic activities aimed at building their attachment and connection to one another. In addition, mothers in this group were provided with education about their children's behaviors and were given the opportunity to work through their own issues pertaining to their frustrations with their children. As both groups progressed (the children's group and the multifamily group) I began to see the importance of the inclusion of the mothers in the therapeutic process, as the mother-child dyads in the multifamily group appeared to be making the most positive progress.

Using a developmental psychopathology framework in addition to social learning theory, trauma theory, and attachment theory as guides in the intervention proved to be very beneficial and contributed a great deal to the effectiveness of the sessions. With an understanding of the reasons behind the children's symptoms according to the theories, I was able to formulate appropriate interventions that proved to be

somewhat effective. In addition, part of the evaluation process included assessing any progress made by the children in their response to the strategies. Therefore, using the explanatory theories was beneficial as they guided the intervention and assisted in the evaluation of the group and individual progress.

Parental Piece

One component that appeared to make the difference in this practicum, as to whether or not a child would make progress, was the inclusion of the mothers in the therapeutic process, and their ability to take away from the group empathy for their child. Also important was the mother's capacity to understand the reasons behind her child's behaviors and attitudes, and to not blame the child. These findings are in accordance with research which has found that the inclusion of the parents in the therapeutic process is important as it helps to ensure that learning that occurs within the group may be extended to the external environment (Jaffe et al., 1986; Peled & Edleson, 1992; Wagar & Rodway, 1995)

Information revealed in supervision sessions with the facilitators of the mother's group suggested that Rob's mother Juli was not able to grasp some of the information presented in the mother's group, and she had a difficult time making the vital connection between Rob's attitudes and behaviors and his experience of domestic violence. During the follow-up interview it also became apparent that Juli had not developed empathy for Rob. In fact, she talked with contempt about Rob, and expressed that she would not be heart broken if Child and Family Services took him away. According to research if a mother is not able to progress, then a child will also

be stagnant in his or her progress (Lewis, 1985; Northen, 1969). This may have been the case with Rob.

More evidence to support this hypothesis was the fact that both Anne and Jane were able to make the vital connection between their children's behaviors and attitudes and the abuse they witnessed, and both Brooke and Jeremy were able to make progress in the group. Jane expressed happiness that she and Jeremy were close as a result of the group, and discussed the influence that the strengthened bond had on decreasing the anger that Jeremy had at intake. Anne discussed the importance of changing her thoughts about Brooke, which she found to be a key factor in bringing Brooke closer to her, which enhanced their relationship and decreased Brooke's aggression. With increased knowledge of family violence learned from the mother's group, and the emergence of empathy, Anne and Jane were able to respond in a more appropriate manner to their child's behaviors and attitudes. The children then responded in a positive way to these new behaviors, and this helped to strengthen the parent-child bond, and helped to improve the issues with which the children presented.

In the children's group, although there was a parental piece, it was not linked to the children's group, and the focus of the mother's group was on personal healing of the mothers with no specific focus on the needs of the children. This appeared to be a contributing factor towards why some of the children were not making progress in the children's group. This conclusion was made based on the progress being made with the children in the multifamily group, as well as the clinical analysis of the children in the children's group. Without support and empathy from their mothers, the children

in the children's group may have had a more difficult time incorporating what they had learned in the group into their lives. Therefore it appeared that the parental piece was important in terms of the children progressing in the group and reaching their goals. Important to note is the fact that there were many other factors at play for each of the children and their mothers. Because these extraneous variables contributed to their experience of the group and their level of success, the parental piece cannot be deemed the sole contributing factor for success or failure.

Knowledge Versus Behavioral Change

Within the group intervention it was clear that the children understood most of the concepts presented within the content of the sessions. This was shown by their ability to give the appropriate answers during games and to integrate what they had learned into the crafts and activities. However, the children had a more difficult time demonstrating their knowledge of the material in their behaviors. In fact, there were many instances both inside and outside of the group where the children did not practice what they had learned. For example, there was one instance outside of the group where Ben physically attacked his mother when she would not buy him a treat from the store. Following this situation during one group session, a question was posed to Ben during a game which asked him what would be the appropriate behavioral response if your mother would not buy you some candy from the store. Ben gave the perfect response to the question, saying that he would talk to her about his feelings that had emerged as a response to her not buying him candy. This answer was the opposite of the physical aggression that he had displayed in the same scenario a few days prior.

As another example, Jake was able to verbally express many appropriate behaviors as opposed to aggression, however he repeatedly acted in an aggressive manner inside and outside of the group. In the group it was important therefore, to allow many opportunities for the children to practice putting the knowledge into action when a situation arose. The content of the group was important, however allowing the children a chance to practice what they had learned appeared to be vital as well. One of the ways this was accomplished was through positive reinforcement of the expression of feelings. This allowed the children to deal with a situation in the "here and now"; it enabled them to apply some of the techniques they had learned, and it appeared to be somewhat effective. Allowing the children the opportunity to practice new behaviors was important within the group context as it assisted the children in their progress.

Parents Requesting Information

In the follow-up meetings and on the post-group evaluation forms some of the parents expressed a desire to know more about what happened in the group. The mothers of the children in the children's group, who were not receiving any information about the children's group beyond what they asked, requested to know the content of the group such as the names of games played. In addition, parents from both groups requested to know the meaning behind the games and activities so that they could be implemented at home. In one case a mother from the children's group asked why her son had cuddled up in a blanket during story time. When she was told that blankets were provided for the children as a way to make them feel more

comfortable during a potentially uncomfortable story, she expressed a desire to know more techniques that she could apply with her son at home.

From this experience, I would recommend having the mothers or primary guardians as an important and central part of the therapeutic process, and I would provide them with plenty of information about the meaning behind the content of the group.

Population

Aggression

Within both of the groups, aggression emerged as a salient theme. Travis in the multifamily group and Jake in the children's group both presented the groups with challenges in terms of controlling their aggressive behaviors. The same strategies were employed with both children in the two groups including the creation of a behavioral plan, positive reinforcement for good behavior, positive reinforcement for the expression of feelings, positive modeling of appropriate behaviors, 1-2-3-magic, and time-outs. Each child responded differently to the strategies applied, and both had a difficult time controlling their aggressive behaviors despite the techniques employed. Travis responded the best to 1-2-3-magic, whereas Jake did not respond favorably to any one of the techniques.

The aggressive behaviors of the children had a definite impact as they put their respective groups in danger. The children expressed to their parents and/or to the facilitators that they were scared of the children who were aggressive. In addition it became apparent that some of the children were intimidated by the boys' behaviors. In Jake's case, in addition to using aggression within the group, he also bullied the

other children and used intimidation tactics to control them. In the group it became apparent that the others were afraid of him. In the case of Travis, his loss of control on two occasions left the children distraught and afraid.

In both cases decisions had to be made as to whether the children in the group would feel safe and comfortable to make their own progress or whether the aggression of the children was too harmful and would inhibit their progress. In Travis's case, the group appeared to be the wrong type of treatment for his more severe symptoms. According to research, when children have more extreme levels of symptoms including behavioral symptoms, group therapy alone does not appear to be suitable (Jaffe et al., 1986; Peled & Edleson, 1992; Wagar & Rodway, 1995). Travis did not appear to be benefiting from the group and instead was having an adverse impact on the rest of the group, therefore it was decided that individual theraplay would be a better option for him.

In Jake's case, although he continued to behave aggressively in the group, his aggressive behaviors were being monitored and controlled by the facilitators and the children in the group appeared to feel secure and comfortable under these circumstances. In addition, Jake seemed to respond well to the group at times and appeared to be learning valuable lessons from his peers with respect to appropriate behaviors. Also, Jake was going through a crisis in his external environment following his disclosure and he was feeling a lot of self-blame and guilt. It was decided that having Jake successfully complete the group would be beneficial for him at that time. Therefore, it was decided that Jake would remain in the group.

Having an aggressive child in each group was a challenging task as each child's aggressive behaviors impeded their individual progress, and impeded the progress of the group as a whole.

Use of Group Work with Child Witnesses

Dynamics of the Population

When facilitating this group for children and families exposed to domestic violence, it was important to consider the dynamics of the population, as these dynamics impacted the progress of the group. A few themes emerged from the dynamics of this population.

In many of the cases in this practicum the mothers were single parents who were solely responsible for the care of their children on many levels including financially, physically, mentally, and emotionally. Not only did these responsibilities add to the stress level of the mothers, but they impacted their attendance in the group as well. For example, transportation, work, and illness were all potential obstacles that decreased the group's attendance. In this practicum there was one circumstance where transportation was a problem where the family lived a half-hour commute to downtown. This made it difficult to attend group and contributed to their poor attendance. In another case, a mother had to work until 5:30pm and then she had to commute a half-hour to group. This resulted in the family coming fifteen minutes late each time they attended the group, which made it more difficult for the child to be comfortable in the group.

In this practicum, getting the group started was difficult, most notably for the multifamily group. Two families who were recruited for the group did not attend a

single session, and more recruiting had to be done when the group had already begun. Attendance was poor at the beginning as well in the multifamily group and this made it difficult for the children to get to know each other and to feel comfortable in the atmosphere of the group. For example, one child attended the first session and did not return until session number four. Three other children had not attended the first session, but attended the second, third, and fourth sessions. When this child attended on the fourth session, the group members had to re-establish a safe and secure environment.

Another dynamic faced by families of domestic violence that impacted their experience of the group, was that many of the women were in a continued struggle to remove themselves from their abusive partner who in many cases had shared custody of the children. In some cases the children were continually exposed to domestic violence through these visits as each parent used the children to get to the other parent. For example, in the post-test evaluation of the children's group when Mark was asked what he learned in the group he said that he learned to "tell my mother to ask him herself". He was referring to the questions that his mother asked him about his dad following visits. In addition, some mothers continued to have contact with their abuser despite restraining orders and better judgement and put themselves in abusive situations that the children were exposed to. One child in the group continued to be exposed to verbal abuse from his father towards his mother, which may have contributed to his inability to make any progress in the group. Some mothers were financially dependent upon their ex-abusers as well, which continued to put them in a position where they could be controlled.

In some cases, women had fled their abusive partners and were "in hiding" or were living under an alias. These circumstances added to the stress level of both the mother and the children and impacted their lives on many levels. If a child does not feel safe he or she may not be able to make progress in the group. In this practicum there were two families who were running from their abuser. One family could not attend group as the abuser had found them and they had to be moved to a safe location. The other family took part in the group and the mother came to the realization that her children could sense her fear and in turn became fearful themselves.

Legal and custody issues were also factors that affected the families in this practicum. To be eligible for the group, mothers had to have full custody of their children or shared custody with primary care and control. Many times the father had shared custody with weekly visits, and under some circumstances the father had to give consent for the child to enter the group. In one case a child could not attend group because his visits with his father were on the same night as the group. In another case, a child's father would not sign the permission forms for his son to attend group. In this situation the child's mother attended the mother's group and expressed discouragement that her son would not have the opportunity to attend the children's group.

All of these unique dynamics had an impact on the families' involvement in the treatment group and in their healing process.

Chapter VI Conclusion

Through the implementation of group treatment with children exposed to domestic violence, I believe that I was able to achieve the learning objectives that were outlined earlier in this practicum. To follow is an overview of this learning process. In addition, recommendations for future work with this population will be identified.

Evaluation of Students Learning Objectives

Three objectives were outlined that I wished to accomplish through the completion of this practicum. First, I wanted to obtain more information on the topic of domestic violence and how it impacted children. There were three sources that contributed to my increased knowledge in this topic area. First, reviewing the literature gave me a solid background and a clear understanding of how domestic violence affects children. Second, direction and knowledge from Dr. Diane Hiebert-Murphy, Linda Perry, and Patty Sutherland, in both the research element as well as the clinical aspect of the topic area enhanced my learning in this area. Third, the actual implementation of the group and my clinical observations of the children were critical in contributing to my knowledge of domestic violence and how it impacts children. This clinical experience took my learning to a level that would not have been possible otherwise.

My second objective was to implement and evaluate a group treatment program for children who had been affected by witnessing domestic violence. This was accomplished through the two groups that I facilitated at EHCC from January to April 2003. This process was an incredible journey and I was amazed at the amount of learning that occurred over the course of four months. Implementation of each group included many steps and components and began with the recruitment process. This

beginning phase took approximately six weeks and was an incredibly frustrating process, as the exact start date could not be confirmed without a confirmed number of clients. Once the groups began they seemed to go by fairly quickly as each week was filled with contact notes, meetings with parents, supervision, and preparation for the next session. Also, facilitating two groups concurrently contributed to a busy schedule. As the groups came to an end, evaluation of the groups was implemented with both the children and their mothers. This component was instrumental in my learning process, specifically the analysis of the measures and comparisons to my clinical analysis of each child's progress.

My third objective was to acquire knowledge about clinical group practice with children impacted by family violence, and to enhance my clinical skills in the group setting. This objective was accomplished through research of the literature, through the experience of facilitating the groups, through weekly supervision sessions with Linda Perry, and through the completion of weekly contact notes. Research of the literature was an important first step to take, however the experience of facilitating the group was the most important factor in allowing me to learn about group work with child witnesses, and to enhance my clinical skills. Just as important was the information that I obtained within supervision sessions. These sessions provided me with valuable insight and education, which helped to strengthen my clinical skills. In addition, completing contact notes each week allowed me to review the strategies employed with each child and assisted me in preparing for the next session, which also contributed to strengthening my clinical skills.

The skills acquired and lessons learned in this practicum may be applied to other populations and other circumstances as well. Therefore, while this practicum increased my knowledge and enhanced my clinical skills with children and families exposed to family violence, the learning may be transferred to other populations. In addition, throughout the practicum process there were many other details learned that were important to social work in general. For example, I learned about family dynamics and the mother-child relationship, I learned the importance of adopting a systemic perspective and its contribution in the therapeutic process, I learned about the importance of explanatory theories as guides to intervention, and I learned about the unique nature of each individual case. Therefore, while I learned much about the population of child witnesses and family violence, this experience gave me many important tools that may be used on a wider scale, and may be applied to the myriad of situations that I will encounter as a social worker in the field.

Evaluation of Client-focused Objectives

The client-focused objectives that were outlined at the beginning of this practicum were for the most part accomplished successfully. The first objective, to educate the children about family violence and to provide them with techniques and strategies that may be applied outside the group setting, was carried out on a weekly basis. Each week the children were educated about a new topic surrounding family violence, and they were informed about different approaches to dealing with the topic and healthy coping mechanisms. In addition the children were given the chance to practice the methods that had been introduced in the safe haven of the group which was the second objective outlined namely to provide a safe environment where

children may understand their feelings and learn new more adaptive behaviors. The third objective, to make positive changes with respect to the behavioral and/or emotional problems that the children presented with, was accomplished in some cases and not in others. Some of the children left the group having made many positive changes, others made only minor progress, and still others did not make sufficient progress and continued to display maladaptive behaviors and emotions. For the most part, all of the parents expressed their happiness with their child's inclusion in the group, even if little or no progress was evident.

Recommendations

Recruitment

The recruitment process included two meetings, one with the parent and a second with the parent and child together. This process worked well as it allowed the parent to feel comfortable in the environment first before their children were introduced to the idea of the group. When it came time for the children to be informed about the group, the mother was prepared herself and in a place where she could help her child feel comfortable with the process. In some cases, when the mother remained uncomfortable during the second meeting, the child also appeared awkward in the presence of his or her mother's tension.

Also important during the recruitment process was spending individual time with the child after he or she had been informed about the topic of the group. During this time, I was able to gauge how the child was feeling and I was able to calm them through the use of games and conversation. Typically, the children would arrive appearing very anxious and nervous, and they would leave excited to return for

group. In addition to making the child feel more comfortable, this individual time was important for me to make a build rapport with them prior to group. The individual connections that I had with each child gave me more control when they were all together in the group. In one instance I had not met with a child until he attended the group because another facilitator had completed the assessment measures with him. I had a difficult time making that individual connection with him within the context of the group and found myself trying to bond with him before and after group. Therefore it was better to have formed that connection prior to group.

The process of accumulating clients for the groups was a difficult and time consuming one which took between six to eight weeks. Most difficult was finding families who fit the criteria that had been outlined. Even when some clients had been recruited and were deemed suitable for the group, personal circumstances removed them from the group and new clients had to be recruited, which set back the start date of the group. I would recommend setting aside a substantial amount of time to account for the difficulties that may arise when starting a group.

Also important in the recruitment process is having in depth screening and assessment of the potential group members. This process will identify children who may not be suitable for a group therapy modality. For example research suggests that some children whose symptoms are too severe may not benefit from the group atmosphere (Jaffe et al., 1986; Suderman et al., 2000; Wager & Rodway, 1995). In other cases some children's personality and/or personal circumstances may contribute to them feeling uncomfortable in a group atmosphere and they may benefit more from a different therapeutic modality.

In addition to screening the children carefully, the mothers are also an important part of the therapeutic process and must be part of an in depth screening process. It is important to include in the group mothers who are fully able and willing to commit to the process and mothers who are motivated to ensure that their children achieve their optimal level of success. Also important is that the mothers understand or have the potential to understand that they are an important part of their child's healthy progress, and that they may have to make some changes themselves as part of the healing process (Jaffe et al., 1986).

During the recruitment process it was difficult to identify mothers and children who fit the criteria perfectly and who had all of the components important for a successful outcome. The two meetings that I had with the families seemed enough to allow me to get to know them and to build the beginnings of rapport with them, however more meetings may have helped to eliminate families who were not suitable for group. Unfortunately time constraints do not always allow for this to occur, however taking time at the beginning of the group to ensure that the group members are suitable will reduce any issues that may emerge as the group proceeds.

One addition that I would make for future groups is the inclusion of a non-formal group setting where all of the children who have been tentatively chosen for the group could interact together. When I met with the children during the screening process it was on an individual basis and the behavior they exhibited one-on-one was different from that in the group setting. When the therapeutic group began and the children were in the group setting it became clear very quickly whether they were suitable for the group setting or not based on their behaviors. In the groups that I facilitated it

was revealed approximately within the first three sessions whether or not a child was suitable for the group setting. Therefore, for future groups the inclusion of some form of group interaction with the children who will be making up the group may be beneficial prior to the beginning of the group. This would allow the facilitator to observe the children's behaviors and to remove any children who are not suitable and refer them to a more appropriate treatment modality. This would also allow the facilitator to form a group of children who are compatible and who will be able to progress and achieve their goals. Informal interaction between the mothers may also be helpful as they may begin to get to know one another casually which may make them more comfortable to share more intimate details within the therapeutic group. In addition this would allow the facilitator to engage with the women and to identify those women who may not be suitable for the group.

Severe Symptoms

Recruiting was a difficult process as just mentioned in both finding clients in general, and finding clients who fit the criteria. Therefore, during the screening process eliminating a child due to a heightened level of symptoms was only an option if the symptoms were extremely severe and the child was noticeably unsuitable for group treatment. Based on the experiences I had with aggressiveness in the two groups, and the impact that the aggressive behavior had on the group as a whole, I would recommend a more in depth assessment of a child who presents with more severe symptoms such as aggression. Not all children who presented as aggressive caused a problem in the group. There were children who were described as aggressive in school and at home at intake who responded well to the group's

atmosphere and who did not exhibit problematic aggressive behaviors within the group. However, other children's aggressive behaviors had immense effects on the group by delaying the progress of the group as a whole and by nearly sabotaging the success of the group altogether. At one point in time in the children's group, many of the mothers expressed concern regarding Jake's aggressive behaviors, and one mother nearly removed her son from the group due to his fear of Jake. Progress was unable to occur when the children felt unsafe.

In addition to impacting the group, the individual who is aggressive may also be affected. For example, in the multifamily group Travis's removal from the group was potentially detrimental to his self-esteem. During the follow-up meeting with him when asked how he was feeling about not coming back to the group he gave a thumbs down and hid his face. He may have felt rejected and discouraged by the consequences of his actions. If Travis had been referred to another treatment modality initially, this outcome could have been avoided. In the case of Jake in the children's group, at one point he said that he did not want to attend the group because he was afraid of hurting someone, and it was too hard for him to control his aggressive behaviors. Although there were many positive outcomes of Jake's successful completion of the group (e.g; he learned appropriate behaviors from peers, he needed one positive accomplishment in light of his external circumstances) a different therapy may have been more effective for him.

Therefore I recommend an in depth screening process to identify children who may be too aggressive for the group.

Continued Exposure

In a few cases, the children in the groups continued to be exposed to verbal abuse from their father towards their mother. This continued exposure to violence while in the treatment group may have made the child feel uncomfortable and confused. For success to occur in therapy it is important that there is no longer any violence in the home. This may mean that the mother is no longer with the abusive male, or that the couple has sought therapy and remain together in a non-violent relationship (Peled & Davis, 1995). According to Peled and Davis (1995) more successful outcomes have emerged when this is the case. If the child is living in an abusive environment while attending group therapy, he or she may not be safe to express his or her thoughts and feelings, and progress may be limited to the confines of the group (Rosenberg & Rossman, 1990). Therefore I recommend investigating these factors in the recruitment process.

Account for Attrition

In my experience, having a larger number of group members to begin with is a good idea, as some members drop out and others have poor attendance. I would suggest starting the group with a minimum of five members and a maximum of seven. When recruiting children for the groups remember that there is a chance that at least one or two families will not attend the group. Considering the unique factors that are characteristic of families exposed to family violence, some recruited families will not be able to attend. For example, in my groups, one child who was recruited could not attend because his father did not sign the permission forms and another

family that was recruited could not attend as they were in danger of being found by the ex-abuser.

If it occurs that all of the families recruited attend the group, the chance that all of the group members will attend every session is not very high. Personal issues and poor weather may be contributing factors. In my case the groups ran from January to April and in Winnipeg these months are characterized by blizzards and freezing temperatures. Clients may have a difficult time transporting themselves to the group under these harsh weather conditions.

Length of Sessions

When determining the length of the session, I would suggest a group for children between the ages of seven and eleven to be no longer than ninety minutes, with an optimal time of seventy-five minutes. In the multifamily group the children's portion was seventy-five minutes in length which I found to be the perfect amount of time to fit in the necessary components but not too long so that the children got restless. The children's group coincided with the mother's group which was two hours in length. This time period was too long for the children who could not stay focused for that lengthy period of time. The children became restless and overly rambunctious in the last half-hour, the room became hot and stuffy over the duration of the night, and the children lost interest in all games and activities. It was difficult to maintain order during the last quarter of the group.

Parental Component

As part of a systemic approach to intervention, the inclusion of mothers in the therapy process appeared to be beneficial to the children's progress in the group.

Results of many studies have suggested the need for maternal involvement in the treatment plan (Jaffe et al., 1986; Peled & Edleson, 1992; Suderman et al., 2000; Wagar & Rodway, 1995), and this practicum would concur with these conclusions based on the clinical analysis and comparison of both groups. Inclusion of mothers in the treatment process may help to ensure that any learning that occurred in the group is not undone by actions of the family members or the nature of the family environment (Wagar & Rodway, 1995). In addition, a mother's involvement in the therapeutic process may help to ensure that the children are not pathologized and are not identified as the main problem. According to Jaffe et al. (1986) the benefits that children acquire from group work may be limited unless the child's parents are committed to ending the violence and instability at home. A mother's inclusion in the therapeutic process may provide her with the necessary education to understand her child's experience and to assist the child in his or her healing journey. Results from this practicum showed heightened success of children when mothers were successfully involved in therapy that addressed parenting issues.

Systemic Approach

Groups should also be part of a larger intervention for children. According to Peled and Edleson (1992) school and community based preventive programs, groups for the individual child, for both the parent and child, and for the family, and advocacy for child witnesses should all be included in an overall-healing program for children. In order for the changes made in the group to last, sources external to the child must also change. Including the child's primary caregiver (the child's mother in most cases) in the treatment process may be the most effective resource for child

witnesses, as this person has the most exposure to and impact on the child in their external environment.

The focus of this practicum was on children in the context of a group. The premise was to help children deal with issues that had emerged as a result of witnessing family violence, in a group format. As the groups progressed however, it became evident to me that in order for firm changes to be made for the individual child, sources external to the child and the group must be impacted as well. The mothers were included in the therapeutic process in this practicum, one group focusing on parenting issues and the other not. Beyond that however, due to time constraints and the narrow focus of the practicum there was little work done beyond the family system.

Theoretical Basis

Another recommendation is that group interventions have a theoretical framework. I found the integration of a developmental psychopathology framework as well as the explanations provided by social learning theory, trauma theory and attachment theory to be very helpful in the treatment and evaluation processes. Initially these theories helped me to better understand the children's symptoms and the intervention process was made easier by using the strategies and techniques based on the tenets of the theories. Also, the theories provided a basis for evaluating the group members. The theories helped to guide the intervention and the evaluation, and without this direction my practicum would have been scattered and disorganized.

Conclusion

Group treatment with child witnesses of domestic violence requires the consideration of many factors, all of which contribute to the success or failure of group intervention. First to prepare for the group, many things must be contemplated. What theoretical orientations will be used to guide the group? What experimental design will be used for the evaluation, and will the methodological shortcomings be limited? Where will the group take place? What is the purpose of the group? Who will make up the group? Once these aspects have been deliberated, the members of the group must be chosen. This task takes much thought and deliberation as the group members determine the success of the group and its members. What are the personal characteristics of the child? Does the child continue to be exposed to a violent environment? Are the child's behaviors considered extreme? Is the mother supportive? What are the mother's intentions for the group? What is their level of commitment?

Once a group of children have been chosen, the group process begins. Things to be considered during the group include: Has there been successful implementation of important session topics that have been outlined in the literature? Are the theoretical strategies being implemented and are they effective? Are the children responding positively to the group? Are the mothers supportive of their children's progress and any behavioral and cognitive changes they have made? Are any unexpected issues that emerge within the group being handled properly and effectively?

Following completion of the group and during the evaluation of the group, many important components should be of focus. Were the goals of each child in the group

reached? What impeded the success of the children? What contributed to the success of the children? What are some recommendations for future groups?

Success of the group intervention depends upon the answers to the questions above. The facilitator of the group plays a large role in ensuring that there are positive answers to the questions. At times however the unpredictable and unique circumstances of each family makes it difficult to create positive answers to the questions. Also unexpected factors may emerge, and despite positive answers to the questions, these factors create disorder in the group progress and prohibit successful outcomes. For example, in this practicum, the importance of the inclusion of the mothers in the therapeutic process was realized after the group was organized and implemented. This unexpected element may have been a contributing factor for the families who did not experience success in the group. At the conclusion of this practicum there were some successful outcomes where the families involved in the group reached all of the goals they had outlined for themselves. In other cases the families did not reach their goals, and left group without any positive changes made.

Overall, group work with child witnesses appears to have promising outcomes, with many positive changes seen in the population of children. When everything falls into place, and all of the questions have been answered positively, the outcome can be tremendously rewarding for the facilitator, and can change the lives of families and children. However when the questions are not answered in a positive manner, or when the atmosphere of group treatment is an improper fit for families, frustration and disappointment may result.

Research and work with this population is still in its infancy as only a few evaluation studies have been completed. However, with continued research and time dedicated to this population of children, more successful outcomes will emerge.

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 profile.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms and profiles.* Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families.

Alessi, J. J., & Hearn, K. (1984). Group treatment of children in shelters for battered women. In A. R. Roberts (Ed.) (1998), *Battered women and their families: Intervention strategies and treatment programs* (pp. 159-173). New York, NY: Springer Publishing Company.

Alexander, P., & Moore, S. (1991). What is transmitted in the intergenerational transmission of violence? *Journal of Marriage & Family, 53*(3), 657-669.

Allen, R. P., Safer, D. J., Heaton, R., Ward, A., & Barrell, M. (1975). Behavior therapy for socially ineffective children. *Journal of the American Academy of Child Psychiatry, 14*, 500-509.

Bandura, A. (1973). *Aggression: A social learning analysis.* Englewood Cliffs, NJ: Prentice-Hall Inc.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall Inc.

Bernstein, S. (Ed.). (1973). *Explorations in group work practice: Essays in theory and practice.* Boston: Milford House Inc.

Bloom, M., Fischer, J., & Orme, J. G. (1999). *Evaluating practice: Guidelines for the accountable professional.* Boston: Allyn and Bacon.

Bowlby, J. (1980). *Attachment and loss, Volume 3: Loss, sadness and depression.* London: The Hogarth Press.

Brandler, S., & Roman, C. (1991). *Group work: Skills and strategies for effective interventions.* New York: Haworth Press.

Carlson, B. E. (1984). Children's observations of interparental violence. In A. R. Roberts (Ed.), *Battered women and their families* (pp. 147-167). New York: Springer.

Carlson, N. R. (1990). *Psychology: The science of behavior* (Third Edition). Boston: Allyn and Bacon.

Carroll, J. C. (1977). The intergenerational transmission of family violence: The long term effects of aggressive behavior. *Aggressive Behavior, 3,* 289-299.

Coolidge, J. C., & Frank, M. G. (1984). Individual and group therapy of a latency-age child. In M. Schiffer (Eds.), *Children's group therapy: Methods and case histories* (pp. 268-279). New York: The Free Press.

Cummings, E. M. (1998). Children exposed to marital conflict and violence: Conceptual and theoretical directions. In G. W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence: Theory, research, and applied issues* (pp. 55-93). Washington, DC: American Psychological Association.

Diagnostic and Statistical Manual of Mental Disorders (4th ed.). (2000). Washington, DC: American Psychiatric Association.

Dobash, R. E., & Dobash, R. P. (1979). *Violence against wives: A case against the patriarchy.* New York: The Free Press.

Edleson, J. L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*(8), 839-871.

Epstein, J. H. (1985). Review of Piers-Harris Children's Self Concept Scale (The way I feel about myself). In J. V. Mitchell Jr. (Ed.), *The ninth mental measurements yearbook* (pp. 1167-1170). Lincoln, Nebraska: The University of Nebraska Press.

Fantuzzo, J. W., DePaola, L. M., Lambert, L., Martino, T., Anderson, G., & Sutton, S. (1991). Effects of interparental violence on the psychological adjustment and competencies of young children. *Journal of Consulting and Clinical Psychology*, 59, 258-265.

Fatout, M. F. (1996). *Children in groups: A social work perspective.* Westport, CT: Auburn House.

Foshee, V. A., Bauman, K. E., & Linder, G. F. (1999). Family violence and the perpetration of adolescent dating violence: Examining social learning and social control processes. *Journal of Marriage & Family, 61*(2), 331-343.

Furlong, M. J., & Wood, M. (1998). Review of the Child Behavior Checklist. In J. C Impara, & B. S. Plake (Eds.), *The thirteenth mental measurements yearbook,* (pp. 220-224). Lincoln, Nebraska: The University of Nebraska Press.

Gaines, T. (1986). Applications of child group psychotherapy. In A. E. Riester, & I. A. Kraft (Eds.), *Child group psychotherapy* (pp. 103-121). Madison: International Universities Press, Inc.

Garland, J. A., Jones, H. E., & Kolodny, R. L. (1973). A model for stages of development in social work groups. In S. Bernstein (Ed.), *Explorations in group*

work: Essays in theory and practice (pp. 17-71). Boston MA: Milford House Inc.

Gelles, R. J. (1999). Family violence. In R. L. Hampton (Ed.), *Family violence 2nd edition: Prevention and treatment* (pp. 1-32). Thousand Oaks: Sage Publications.

Gelles, R. J., & Cornell, C. P. (1985). *Intimate violence in families.* Beverly Hills: Sage Publications.

Ginott, H. G. (1961). *Group psychotherapy with children: The theory and practice of play-therapy.* New York: McGraw-Hill Book Company.

Glass, D., & Thompson, S. (2000). Therapeutic group work. In K. N. Dwivedi (Ed.), *Post-traumatic stress disorder in children and adolescents* (pp. 163-183). London: Whurr Publishers.

Graham-Bermann, S. A. (1998). The impact of woman abuse on children's social development: Research and theoretical perspectives. In G. W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence: Theory, research, and applied issues* (pp. 21-54). Washington, DC: American Psychological Association.

Graham-Bermann, S. A. (2001). Designing intervention evaluations for children exposed to domestic violence: Applications of research and theory. In S. A. Graham-Bermann, & J. Edleson (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 237-267). Washington, DC: American Psychological Association.

Graham-Bermann, S. A. & Levendosky, A. A. (1997, April). *The social functioning of preschool-age children whose mothers are emotionally and physically abused.*

Paper presented at the bienneal meeting of the society for research in child development, Wachington, DC.

Graham-Bermann, S. A., & Levendosky, A. A. (1998). Traumatic stress symptoms in children of battered women [Electronic version]. *Journal of Interpersonal Violence, 13*(1), 111-129.

Grusznski, R. G., Brink, J. C., & Edleson, J. L. (1988). Support and education groups for children of battered women. *Child Welfare, 67*, 431-444.

Grych, J. H., Jouriles, E. N., Swank, P. R., McDonald, R., & Norwood, W. D. (2000). Patterns of adjustment among children of battered women. *Journal of Consulting and Clinical Psychology, 68*(1), 84-94.

Harris, S. M., & Dersch, C. A. (2001). "I'm just not like that": Investigating the intergenerational cycle of violence. *Family Journal, 9*(3), 250-258.

Herndon, C. H. (1985). Stage V: Termination. In B. B. Siepker, & C. S. Kandaras (Eds.), *Group therapy with children and adolescents: A treatment manual* (pp. 157-175). New York, NY: Human Sciences Press, Inc.

Herzberger, S. D. (1983). Social cognition and the transmission of abuse. In D. Finkelhor, R. J. Gelles, G. T. Hotaling, & M. A. Straus (Eds.), *The dark side of families: Current family violence research* (pp. 317-329). Beverly Hills: Sage Publications.

Holden, G. W., & Ritchie, K. L. (1991). Linking extreme marital discord, child rearing, and child behavior problems: Evidence from battered women. *Child Development, 62*, 311-327.

Hughes, H. M., Graham-Bermann, S. A., & Gruber, G. (2001). Resilience in children

exposed to domestic violence. In S. Graham-Bermann, & J. Edleson (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 67-90). Washington, DC: American Psychological Association.

Hughes, H. M., & Luke, D. A. (1998). Heterogeneity in adjustment among children of battered women. In G. W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence: Theory, research, and applied issues* (pp. 185-221). Washington, DC: American Psychological Association.

Huth-Bocks, A., Levendosky, A., & Semel, M. (2001). The direct and indirect effects of domestic violence on young children's intellectual functioning. *Journal of Family Violence, 16*(3), 269-290.

Jaffe, P., Wilson, S., & Wolfe, D. A. (1986). Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. *Canadian Journal of Behavioral Science, 18*(4), 356-366.

Jaffe, P., Wilson, S. K., & Wolfe, D. (1988). Specific assessment and intervention strategies for children exposed to wife battering: Preliminary empirical investigations. *Canadian Journal of Community Mental Health, 7*(2), 157-163.

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1990). *Children of battered women.* Newbury Park: Sage Publications.

Jernberg, A. M. (1979). *Theraplay: A new treatment using structured play for problem children and their families.* San Francisco: Jossey-Bass Publishers.

Jeske, P. J. (1985). Review of Piers-Harris Children's Self Concept Scale (The way I feel about myself). In J. V. Mitchell Jr. (Ed.), *The ninth mental measurements*

Yearbook (pp. 1169-1170). Lincoln, Nebraska: The University of Nebraska Press.

Johnston, M. E. (1988). Correlates of early violence experience among men who are abusive toward female mates. In G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. Straus (Eds.), *Family abuse and its consequences: New directions in research* (pp. 192-299). Newbury Park: Sage Publications.

Jouriles, E. N., Spiller, L. C., Stephens, N., McDonald, R., Swank, P. (2000). Variability in adjustment of children of battered women: The role of child appraisals of interparent conflict. *Cognitive Therapy and Research, 24*(2), 233-249.

Juristat: Canadian Centre for Justice Statistics. (June 2001). *Children witnessing family violence.* [Brochure]. Dauvergne, M., & Johnson, H.: Authors.

Kalmus, D. (1984). The intergenerational transmission of marital aggression. *Journal of Marriage and the Family, 46,* 12-19.

Kandaras, C. S. (1985). Stage IV: Cohesion. In B. B. Siepker, & C. S. Kandaras (Eds.), *Group therapy with children and adolescents: A treatment manual* (pp. 137-156). New York, NY: Human Sciences Press, Inc.

Kilpatrick. K. L. & Williams, L. M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry, 67*(4), 639-644.

Kirst-Ashman, K. K., & Hull, G. H. (1999). *Understanding generalist practice.* Chicago: Nelson-Hall Publishers.

Lampel, A. K. (1985). Stage II: Exploration. In B. B. Siepker, & C. S. Kandaras (Eds.), *Group therapy with children and adolescents: A treatment manual* (pp. 86

-109). New York, NY: Human Sciences Press, Inc.

Lehmann, P. (1997). The development of post-traumatic stress disorder (PTSD) in a sample of child witnesses to mother assault. *Journal of Family Violence, 12*(3), 241-257.

Levendosky, A. A. & Graham-Bermann, S. A. (1998). The moderating effects of parenting stress on children's adjustment in woman-abusing families. *Journal of Interpersonal Violence, 13*(3), 383-397.

Levendosky, A. A. & Graham-Bermann, S. A. (2000). Trauma and parenting in battered women: an addition to an ecological model of parenting. *Journal of Aggression, Maltreatment, & Trauma, 3*(1), 25-35.

Levendosky, A. A. & Graham-Bermann, S. A. (2001). Parenting in battered women: The effects of domestic violence on women and their children. *Journal of Family Violence, 16*(2), 171-191.

Levendosky, A. A., Huth-Bocks, A. C., Semel, M. A. & Shapiro, D. L. (2002). Trauma symptoms in preschool-age children exposed to domestic violence. *Journal of Interpersonal Violence, 17*(2), 150-164.

Levendosky, A. A., Huth-Bocks, A. C., Shapiro, D. L., & Semel, M. A. (2003). The impact of domestic violence on maternal-child relationship and preschool-age children's functioning. *Journal of Family Psychology, 17*(3), 275-287.

Lewis, L. H. (1985). Stage III: Anxiety. In B. B. Siepker, & C. S. Kandaras (Eds.), *Group therapy with children and adolescents: A treatment manual* (pp. 110-136). New York, NY: Human Sciences Press, Inc.

Litrownik, A. J., Newton, R., Hunter, W. M., English, D., & Everson, M. D. (2003).

Exposure to family violence in young at-risk children: A longitudinal look at the effects of victimization and witnessed physical and psychological aggression. *Journal of Family Violence, 18*(1), 59-73.

MacEwen, K. E. (1994). Refining the intergenerational transmission hypothesis. *Journal of Interpersonal Violence, 9*(3), 350-365.

McDonald, R., Jouriles, E. N., Norwood, W., Ware, H. S., & Ezell, E. (2000). Husbands' marital violence and the adjustment problems of clinic-referred children. *Behavior Therapy, 31,* 649-665.

Malekoff, A. (1997). *Group work with adolescents: Principles and practice.* New York: The Guilford Press.

Miller, N. E., & Dollard, J. (1941). *Social learning and imitation.* New Haven: Yale University Press.

Moore, J. G., Galcius, A., & Pettican, K. (1981). Emotional risk to children caught in violent marital conflict-the basildon treatment. *Child Abuse and Neglect, 5,* 147-152.

Moore, T. E., & Pepler, D. J. (1998). Correlates of adjustment in children at risk. In G. W. Holden, R. Geffner, & E. N., Jouriles (Eds.), *Children exposed to marital violence: Theory, research, and applied issues* (pp. 157-184). Washington, DC: American Psychological Association.

Morrel, T. M., Dubowitz, H., Kerr, M. A., & Black, M. M. (2003). The effect of maternal victimization on children: A cross-informant study. *Journal of Family Violence, 18*(1), 29-41.

Northen, H. (1969). *Social work with groups.* New York: Columbia University

Press.

Northen, H., & Kurland, R. (2001). *Social work with groups; 3rd ed.* New York: Columbia University Press.

O'Keefe, M., & Lebovics, S. (1998). Intervention and treatment strategies with adolescents from maritally violent homes. In A. R. Roberts (Ed.), *Battered women and their families: Intervention strategies and treatment programs.* (pp. 174-202). New York, NY: Springer Publishing Company.

Peled, E., & Davis, D. (1995). *Groupwork with children of battered women: A practitioner's manual.* Thousand Oaks: Sage Publications.

Peled, E., & Edleson, J. L. (1992). Multiple perspectives on groupwork with children of battered women. *Violence and Victims, 7*(4), 327-342.

Peled, E., & Edleson, J. L. (1995). Process and outcome in small groups for children of battered women. In E. Peled, P. J. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 77-96). Thousand Oaks, CA: Sage Publications.

Pepler, D. J., Catallo, R., & Moore, T. (2000). Consider the children: Research informing interventions for children exposed to domestic violence. In R. Geffner, P. J. Jaffe, & M. Suderman (Eds.), *Children exposed to domestic violence: Current issues in research, intervention, prevention, and policy development* (pp. 37-59). New York: The Haworth Press Inc.

Piers, E. V. (1984). *Piers-Harris children's self-concept scale; Revised manual 1984.* Los Angeles, CA: Western Psychological Services.

Reitzel-Jaffe, D., & Wolfe, D. A. (2001). Predictors of relationship abuse among

young men. *Journal of Interpersonal Violence, 16*(2), 99-115.

Rose, S. R. (1998). *Group work with children and adolescents: Prevention and intervention in school and community systems.* Thousand Oaks: Sage Publications.

Rose, S. D., & Edleson, J. L. (1987). *Working with children and adolescents in groups: A multimethod approach.* San Francisco: Jossey-Bass Publishers.

Rosenberg, M. S., & Rossman, R. (1990). The child witness to marital violence. In R. T. Ammerman, & M. Hersen (Eds.), *Treatment of family violence: A sourcebook* (pp. 183-210). New York: John Wiley & Sons.

Rossman, B. B. R. (1994). Children in violent families: Diagnostic and treatment considerations. *Family Violence and Sexual Assault Bulletin, 10*, 29-34.

Rossman, R. (2001). Longer term effects of children's exposure to domestic violence. In S. Graham-Bermann, & J. Edleson, (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 35-65). Washington, DC: American Psychological Association.

Rutter, M. (1995). Clinical implications of attachment concepts-retrospect and prospect. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 36,* 549-571.

Rutter, M., & Sroufe, A. L. (2000). Developmental psychopatholgy: Concepts and challenges. *Development and Psychopathology, 12*, 265-296.

Sameroff, A. J. (2000). Developmental systems and psychopathology. *Development and Psychopathology, 12*, 297-312.

Schaefer C. E., Johnson, L., & Wherry, J. N. (1982). *Group therapies for children*

and youth: Principles and practices of group treatment. San Francisco: Jossey-Bass Publishers.

Schnitzer de Neuhaus, M. (1985). Stage I: Preparation. In B. B. Siepker, & C. S. Kandaras (Eds.), *Group therapy with children and adolescents: A treatment manual* (pp. 54-85). New York, NY: Human Sciences Press, Inc.

Siepker, B. B. (1985). Stage VI: Closure. In B. B. Siepker, & C. S. Kandaras (Eds.), *Group therapy with children and adolescents: A treatment manual.* (pp. 176-193). New York, NY: Human Sciences Press, Inc.

Siepker, B. B., & Kandaras, C. S. (Eds.). (1985). *Group therapy with children and adolescents: A treatment manual.* New York, NY: Human Sciences Press Inc.

Simons, R. L., & Lin, K. H. (1998). Socialization in the family of origin and male dating violence: A prospective study. *Journal of Marriage & Family, 60*(2), 467-478.

Slavson, S. R. (1986). Different methods of group therapy in relation to age levels. In A. E. Riester, & I. A. Kraft (Eds.), *Child group psychotherapy: Future tense* (pp. 9-27). Madison, Connecticut: International Universities Press, Inc.

Stedman, J. M., Peterson, T. L., & Cardarelle, J. (1971). Application of a token system in a pre-adolescent boys' group. *Journal of Behavior Therapy and Experimental Psychiatry, 2*, 23-29.

Straus, M. A. (1992). *Children as witnesses to marital violence: A risk factor for lifelong problems among a nationally representative sample of American men and women.* Paper presented at the Ross Roundtable on "Children and Violence,": Washington, DC.

Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). *Behind closed doors: Violence in the American family.* Garden City, NY: Anchor Books.

Sudermann, M., Marshall, L., & Loosely, S. (2000). Evaluation of the London (Ontario) community group treatment programme for children who have witnessed woman abuse. In R. A. Geffner, P. G. Jaffe, & M. Sudermann (Eds.), *Children exposed to domestic violence: Current issues in research, intervention, prevention, and policy development* (pp. 127-139). New York: The Haworth Press, Inc.

Svanberg, P. O. G. (1998). Attachment, resilience and prevention [Electronic version]. *Journal of Mental Health, 7*(6), 543-579.

Swinford, S. P., Demaris, A., Cernkovich, S. A., & Giordano, P. C. (2000). Harsh physical discipline in childhood and violence in later romantic involvements: The mediating role of problem behaviors. *Journal of Marriage & Family, 62*(2), 508-519.

Toseland, R. W., & Rivas, R. F. (2001). *An introduction to group work practice: 4th Ed.* Boston: Allyn and Bacon.

Wagar, J. M., & Rodway, M. R. (1995). An evaluation of a group treatment approach for children who have witnessed wife abuse. *Journal of Family Violence, 10*(3), 295-306.

Ware, H. S., Jouriles, E. N., Spiller, L. C., McDonald, R., Swank, P. R., & Norwood, W. D. (2001). Conduct problems among children at battered women's shelters: Prevalence and stability of maternal reports. *Journal of Family Violence, 16*(3), 291-307.

Webb, N.B. (1996). *Social work practice with children.* New York: The Guilford

Press.

Wilson, S., Cameron, S., Jaffe, P., & Wolfe, D.(1989). Children exposed to wife abuse: an intervention model: *Social Casework, 70*, 180-192.

Wolak, J., & Finkelhor, D. (1998). Children exposed to partner violence. In J. J. Jasinski, & L. M. Williams (Eds), *Partner violence: A comprehensive review of 20 years of research* (pp. 73-111). Thousand Oaks: Sage Publications.

Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A., & Jaffe, P. G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review,6(3)*, 171-187.

Wolfe, D., Zak, L., Wilson, S., & Jaffe, P. (1986). Child witnesses to violence Between parents: Critical issues in behavioral and social adjustment. *Journal of Abnormal Child Psychology, 14*, 94-104.

Appendixes

Appendix A

Group Outline

The group ran for a duration of 12 weeks. The multifamily group consisted of a total of ten sessions with the children's group lasting 75 minutes in length (the group lasted a total of two hours with forty-five minutes dedicated to the multifamily portion), and the children's group consisted of a total of eleven sessions with each session lasting 120 minutes in length. The following outline was used for both of the groups. Because the two groups were different in terms of length and the inclusion or exclusion of a multifamily component, there were slight differences in their content.

Session One

General introduction to the group; Getting to know each other.

- Check-in. In the check-in circle the children will be introduced to the format where they will use the feelings circle and feeling faces chart to describe a feeling they are feeling and why. They will each have an arrow to place on the feeling they are having. Introduce the lock box and "Secret Sammy" and discuss confidentiality.
- Play the Circle Name Game: The children say their name and one thing about themselves. Go around the circle and have each child repeat the names with the favorite thing of everyone in the circle.
- Introduce the topic of the group: Describe the purpose of the program, that all of the children have seen fighting in their families. Did they know that there were

other children like them? Their mothers are in a group also, and are learning about their children's behaviors, and ways to be a good parent.

- Visual Agenda: Show the visual agenda and explain the different areas of the room (craft corner, check-in circle, game area).
- Craft; Name Envelopes: Have the children use a variety of materials to decorate their own envelope. Each envelope will have the child's name on it as well as activities that would best describe them. Come back to the circle when finished and have each child present their envelopes.
- Games: Cotton Ball Throw, Tug of War.
- Check-out: What did the children like best about the group today and why? Volunteer a child to describe what we did in group today.[1]
- Join mothers for snack and games.[1] (The Thursday evening Children's group had snack halfway through the session)

Session Two

Feelings.

- Check-in: Introduce "Secret Sammy" to those children who have not met him, and incorporate him into the check-in. Make a ritual of opening his box and including him in the discussion. What feelings are you having today and why? Have the children place their arrows on their feeling. Reintroduce the topic of the group: Fighting in families.
- Visual Agenda

[1] An activity that occurred only on the Wednesday evening Multifamily Group Treatment

- Brainstorm group rules: Have the children help to make some rules for the group. Important rules to include: confidentiality, no hurts, stick together, have fun, respect others, use your ears, stay in the room unless a leader says you can leave. If you want to leave ask a leader first, keep your hands to yourself.
- Brainstorm different kinds of feelings.
- Watch video; Mad, Sad, Glad
- Questions about Video

1. Is it okay to have more than one feeling at once?
2. How do you know how someone is feeling? How do you know when you are angry?
3. What is the difference between the way we feel and how we act? Can we control what we are feeling? Can we control how we act? *We can't control how we feel, but we can control how we act.*
4. What are some things that you can do when you are angry besides what you mentioned above? *(do something active like tug of war, or kick a ball; write a story expressing your feelings; draw a picture expressing your feelings; talk to someone about your feelings).*

- Feelings Game: The children will sit in a circle, and will pick a paper out of a pile that describes a situation. They then say how they would feel in that situation. i.e., "You are playing a game with a friend, and your friend keeps winning. How do you feel?"

- Craft[2]: Make puppets out of brown paper bags. Make the puppet into the animal that best describes them. After they are finished the children will tell group why they picked the animal, and why it describes them.
- More Games: Touch colors, newspaper punch, newspaper toss, feelings charades.
- Check-out:
- Mothers join for snack and games.[1]

Session Three

Different kinds of hurting.

- Check-in: What feelings are you having and why.
- Show and Tell
- Brainstorm different kinds of hurting: Brainstorm with the children different ways that people can hurt each other. After brainstorming, have the children help to put the different kinds of hurting into one of three different categories: hurting with words, hurting physically, and hurting sexually. *Note: All kinds of abuse are equally hurtful.*
- Puppet show: Have a few different skits portraying different kinds of hurting, and the children will guess what type of hurting it is (skits outlined below).
- Craft: "What Hands Can Do". Do a big poster first where all of the children contribute and when they are doing their craft they can look at the poster for help

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[2] An activity that occurred only in the Children's Group

with the different kinds of hurting. The children trace their hands onto a sheet of paper. On one hand they write how hands can hurt people, and on the other hand they write how hands can help people. Cut out hands, glue them together with a popsicle stick in between.

- Games: Hot potato with questions about different kinds of hurting, blindfold friend guess, cotton ball blow.
- Check-out
- Mothers join for snack and games.[1]

Session Four

Fighting in families.

- Check-in: Remind the children about the topic of the group: Fighting in families. Review the different kinds of hurting from last week.
- Read Book: A Family That Fights by Sharon Chesler Bernstein. Questions:

1. How do these children feel when their mother is getting hurt?
2. Should they get in the middle when mother and dad are fighting? Why not?
3. How did these children keep themselves safe from the fighting?
4. Is the fight between mother and dad the children's fault? Did someone make dad blow up?
5. Do you think these children have confused feelings about loving their dad, but hating what he does?

- Exercise: Have the children draw a picture of some fighting they have seen or heard in their family (or elsewhere), and have them each present their pictures to the group afterwards (If they feel comfortable). Put pictures in craft envelope.

- Games: Tug of War, Duck duck goose HUG, Who Started the Action, Statues, Snakes in the grass.
- Coat of Arms: The children use a coat of arms and draw different things about themselves such as 'What are you good at?' 'What would you like to get better at?'
- Check-out
- Mothers join for snack and games.[1]

Session Five

Fighting in families should never be a secret.

- Check-in: What is a secret? What is a good secret and what is a bad secret? What is the difference between the two?
- Read Book: "Clover's Secret" by Christine Winn and David Walsh.

Questions about book:

1. Why do you think Clover could not fly?
2. How did Clover feel when her friend Micky tried to help her to learn to fly?
3. What did Micky tell Clover to do after she saw Clover's parents fighting? Was that good advice?

-Ask the children how the secret of family violence was broken in their family.

- Reasons for keeping a secret: Brainstorm with the children reasons why they don't want/like to talk about what is happening in their family.

<u>Possible Reasons</u>:

1. They are scared their mother or dad may go to jail.
2. They are scared that no one will believe them.

3. If they talk, then the whole family will be upset and sad.
4. They don't talk because they blame themselves for the fighting.
5. Someone threatened them or scared them.
6. Someone gave the child a present (bribe) and told them not to tell.
7. They are scared that they won't be able to live with their family anymore.
8. They may think that fighting in families is normal.

-Go over each reason with the children and give them explanations why each of their worries are valid but can be overcome.

-Open cookies with affirmations in them and have the children read each, one at a time.

Affirmations:

1. When feelings are hurt, and put-downs are used a lot in a family, or bodies are hurt because of a fight in a family, THIS IS NOT OKAY.
2. It is not your fault when your parents fight. Adults are responsible for their own behavior.
3. Getting help to protect yourself is important, NO MATTER WHAT!
4. You have the right to tell someone safe like your grandma or your teacher about the fighting in your family even if your family tells you to keep it a secret.
5. You have the right to tell someone how you are feeling and what is happening in your family, even if you think someone may get upset or sad if you tell. Actually, they may feel happy that you told someone, and proud of you too!
6. You have the right to tell your story to someone and have them believe you and help you.

7. You have a right to be safe and happy.
8. You are not the only child who has seen or heard fighting in their family. There are many others just like you.
9. It is up to the adults in my life to keep me safe.
10. When fighting happens in my family my job is to keep safe.

- Responsibility discussion and puppet show:

(A) Discussion:

-Often children or adults who have been hurt feel somehow responsible for the violence that has happened. For example, remember Max from last week? He thought that he was responsible for his mother and dad fighting because he needed hotdog money. Was it Max's fault? Whose fault was it?

-Other times children think that it is their mother's fault when they get hurt and if they didn't talk back to their dad then they wouldn't get hurt. Is this true? Whose fault is it when mother gets hurt?

Responsibility for the violence lies with the person perpetrating the violence.

Violence is about a choice and people can choose not to be violent.

(B) Do puppet show skits and have the children guess who is responsible for the violence.

Puppet Shows for Responsibility:

Skit #1: (Kate: Mother, Jason: son)

Kate: Jason could you help me put this huge casserole in the oven?

Jason: Yeah, hold on a minute.

Kate: Hurry up, it has to go in right now if we're going to eat on time.

Jason: Just a minute (yelling)

Kate: (mumbling) If anything is going to get done, I have to do it myself. (She struggles with the casserole and tries to put it in the oven herself). I'll just do it without his help. Argh,,, oh my this is heavy,,, argh,,,ohhhhhh! (She drops the casserole and it crashes to the ground).

Jason: (Comes into the room) What is going on in here!

Kate: If you would have helped me, it wouldn't have dropped! Now dinner is ruined. (She hits him and runs away).

Skit #2: (Jason: Son, Kate: Mother, Jim: Dad)

Jason: Hi mother, Hi dad I'm home.

Kate and Jim: Hi

Kate: (to Jim): No I didn't!

Jim: Yes you did, you gave him a ride to school this morning without asking me for the car first.

Kate: I asked you this morning when you were still in bed, don't you remember? (crying). (Turns to Jason) Jason, go to your room.

Jim: No Jason, stay here and tell me what happened this morning. Did you hear your mother ask me to borrow the car?

Jason: ummmm, I.....don't remember.

Jim: Yes you do, your just trying to protect you mother. Now tell me!

Jason: I don't know! (yelling, and runs to his room).

Jim: (to Kate) You are a liar Kate (hits her). Now stop lying to me! Did you take the car to drive Jason to school this morning? (hits her again).

Kate: yes.

Jim: Did you ask me first? (hits her again)

Kate: Yes I did.

Jim: Liar!

(They continue to fight as Jason listens at the top of the stairs)

Jason: It's all my fault that they are fighting. Oh no.

Skit #3: (Jason: Son, Eric: Friend, Jim: Dad)

Jason and Eric are playing catch

Jim: Jason, time for dinner!

Jason: Can Eric come for dinner?

Jim: Jason, come her now!

Jason: Can Eric come over for dinner?

Jim: Get over here...NOW!

Jason walks over to his dad and his dad grabs him by the arm and drags him inside.

Jim: Don't you ever ask me that in front of your friend again. If I wanted to have him for supper, I would have invited him myself. Now get inside.

- Games: Popcorn throwing contest (into mouth of partner), stack of hands with lotion, cotton ball race with straws.
- Activity: Make slime out of baking soda, water, and food coloring.

- Check-out
- Mother's join for snack and games.[1]

Session Six

Mixed-up feelings.

- Check-in: What feelings are the children having and why?
- Discuss mixed up feelings and remind the children how they can have more than one feeling at once.
- Read Book: "Mom and Dad Break Up" by Joan Singleton Prestine.
- Craft/Activity: "Feeling Paper Dolls": The children use different faces on paper dolls to show the different feelings they had when their mother and dad broke up.
- Games: Tunnel, peanut butter and jelly, taste test.
- Check-out
- Mothers join for snack and games.[1]

Session Seven

Feeling afraid.

- Check-in: Today we will be talking about feeling afraid, what happens in our bodies that let's us know we are afraid, and what we can do about it. Can anyone remember a time when their parents were fighting that they were afraid? What happened to them in their bodies that made them think they were afraid? What did they do?
- Read Book: "Feeling Afraid" by Joy Berry

Questions:

1. How did Kim hurt his arm?

2. How did he feel when he was climbing the tree? And when he was at the hospital?
3. What kinds of things make children feel afraid?
4. Do you know anybody who does not feel afraid at least some of the time?

- Body Tracing: The facilitators will trace the outline of all of the children's bodies, and will ask them to draw what happens to their body when they are afraid. Examples of what may happen include:

  -Your heart may beat faster

  -You might breathe harder

  -You might perspire more

  -Your stomach may feel upset

  -Your muscles might feel tense

  -You might feel weak

  -You might suddenly need to go to the bathroom

- Games: Tunnel, clap a pattern Clap a pattern, Simon Says, Name that tune (each person whistles a tune and the rest have to guess what the tune is).
- Power Planning: Let the children know that they are not responsible for the violence between their parents, however sometimes they themselves may be in danger so they must learn how to protect themselves. Read story about Jerry (attached) and then play Jeopardy (Jeopardy questions related to the story and safety planning).
- Check-out

- Mothers join for snack and games[1]

Jerry: Feeling Afraid/Protection Planning

One night Jerry the Giraffe was in the jungle playing his favorite game, pick up sticks when he heard loud shrieks coming from the river. He looked through the trees and noticed that Al and Ally, the two alligators were yelling at each other. Jerry the Giraffe tried to ignore them and continued to play his game. They were fighting about bugs. Al hated eating beetles for dinner, but those were the easiest bugs for Ally to catch, and she cooked them for dinner all the time. The yelling got louder and louder and Jerry started to get worried. He got a funny feeling in his stomach. A few feet away from Jerry was Mitzey the mouse. She hated when the alligators fought, especially about food, because she knew what Al's most favorite meal was, mice. After about 10 minutes of listening to Al and Ally the alligators yelling at each other, Mitzy went out to find her best friend Jerry the Giraffe. He always helped her when she was scared. When Mitzey found him, she scurried up Jerry's tail, crawled across his back and stopped on his head right in between his eyes "I'm scared Jerry", said Mitzey. "If Al gets too mad he'll come looking for better food than the beetles." "I'll protect you" said Jerry. "Let's go to the other side of the Jungle and play in the tall grass, we can play hide and seek. That way we'll be far away from Al and Ally, and they won't be able to find us". Jerry took Mitzey to the other side of the jungle and the two of them played hide and seek. Jerry always lost though because of his long legs and long neck. While he was hiding from Mitzey he was thinking about Ally and hoping that she was okay. He knew that when Al got really angry he would sometimes swat her with his big tail. He knew that he was doing the right thing

though by staying away from them, because he didn't want Al to get Mitzy for dinner, also, alligators would take a bite out of a giraffe to if they were really hungry. So they played until it got dark and Jerry had to go home for supper. "Mitzey, do you want to come to my place for dinner? My parents are making Caterpillar stew!"

"Okay, let's go!"

Session Eight

Angry feelings.

- Check-in
- Puppet show and questions about anger.

Puppet Show about Anger:

Narrator: Jack and his wife Lara are driving home from work. It is rush hour and Jack hates rush hour traffic.

Jack: I hate rush hour traffic. People don't know how to drive properly in rush hour. Gas, brake, gas, brake....sooooo annoying, argh.

Lara: Calm down, you always get like this when we are driving home. You should just get used to it.

Jack: Easy for you to say, you're not driving. (He yells out the window) "Move it slowpoke!"

Lara: Jack! The light is red, he can't move, now stop yelling. Your hands are gripped so tightly around that steering wheel that your knuckles are white! And you have such an angry look on your face, you need to take a few deep breaths.

Narrator: All of a sudden a car slams into the back of Jack and Lara's car. Jack gets out of the car and walks towards the car that rear ended them. Lara is concerned what Jack will do because he is so angry.

Jack: (Yelling) You should watch where you're going you numbskull.

Driver of car: Oh my Gosh, I'm soo sorry. Here, I'll give you my number and we can sort this out later.

Jack: I don't think so buddy, we're going to sort this out now. Get out of the car so I can sort you out.

Driver: I don't want to get into a fight with you. This was an accident, just calm down.

Narrator: Jack's face was red and he was sweating. The driver of the car decided that it would not be safe to get out of his car. So he stayed inside to wait for Jack to calm down. Jack began to pace back and forth. Lara got out of the car and approached Jack.

Ask questions here

Lara: Jack what are you doing? You are just making the situation worse. It was just an accident, let's get his number and go.

Jack: You're right Lara, it was an accident. And remember last winter when *I* rear ended a car on the way home from the gym? That was an accident too, and the guy that I hit was very nice about it.

Lara: That's right.

Narrator: Jack takes a few deep breaths to calm down before approaching the car. The other driver slowly rolls down his window.

Jack: Hey, I'm sorry for flipping out on you. It was just an accident, not a big deal. Here, give me your number and I'll call you tonight so we can switch insurance details.....Thanks, have a great day.

Narrator: Jack and Lara drive home and Jack is much more calm.

Jack: (to Lara): I'm sorry for getting so angry.

Lara: That's okay.

Questions:

1. What feeling is Jack having about driving in rush hour traffic and when he got rear ended.
2. How do you know that Jack is angry? What is he doing that makes you think he is angry?
3. How do you feel when you get angry? Do some of the things that happened to Jack happen to you when you are angry? (Red face, sweating, clenched fists)
4. What makes you angry?
5. What do you do when you get angry? (talk about it, avoid it, get into conflicts)
6. How do people in your family show anger? How do you know when your mother is angry? Your dad?
7. What should Jack do now to make the situation better, and to control his anger before he does something he shouldn't do?

- Read book: "Feeling Angry" by Joy Berry.
- Activities: Complete two handouts: "Draw what anger looks like to you" and "Safe ways to express anger, When I get angry I can...".

- Make an "Anger Volcano": Build a volcano using baking soda, red food coloring, and dish soap. Put all into a jar with tin foil around it. Add vinegar to make the erupting volcano. It erupts more each time you add more vinegar. Message: This is what may happen with your anger if you don't deal with it properly. If we keep anger inside it can erupt just like a volcano.
- Games: Taste test, children eat m&m's off of different parts of their bodies and the rest of the group copies them.
- Check-out
- Mothers join for snack and games.[1]

Session Nine

Getting along with others.

- Check-in: Remind the children that next week is the last session. Discuss feelings that they may be having about the group coming to an end. Review all of the sessions/themes with the group.
- Brainstorm with the children what makes a good friend.
- Game: "Magic Carpet Ride": The children learn some qualities that are important to being a good friend as they visit four different 'lands': The land of cooperation where they must all work together to build a puzzle, the land of taking your turn where the children must all share a bubble blower, the land of being polite where the children have a tea party and use please and thank-you's, and the land of sharing where the children must all draw a picture sharing different colored markers.

- Craft: The children will make the first half of the craft that they will be giving to their mothers in the last session. We will be making a picture frame with a spring theme on it and the children can write a nice message on it as well. We will also take pictures of the children that may be put into the frames next week.
- Games: Cotton ball tickles, feather blow (where the children have to keep a feather up by blowing it), memory (with pictures and messages of ways to be a good friend).
- Jeopardy II^2 (With story about being a good friend; Sally the skunk).

Jeopardy II

Sally was a skunk who lived in the swamp with all of her friends. Sally loved to play follow the leader in the swamp with her friends, and she loved to be the leader. One morning Sally woke up late and missed the beginning of the game. Her friends had already started and Billy the Buffalo was the leader this time. Sally ran up to Billy and said, "Move it, I'm always the leader" and she raised her tail and threatened to spray him. Billy got scared and moved to the back of the line and let Sally lead. The next day Sally made sure to get up early so that there would not be a repeat of what happened yesterday, she wanted to be the leader. On her way to the swamp, she lost her way and ended up in a lush forest. Eventually she found her way to the swamp, but she was too late again, today Perry the possum was leading the game. "Perry, didn't you hear what I said yesterday? I am always the leader! Get out of my way!" This time Sally was so angry that she sprayed Perry with her skunk spray. Perry ran away from the game and was crying. Sally began to lead the game, and she looked behind her and noticed that no one was following her. They were all with Perry,

trying to make him feel better. Sally got angry and stormed away. That night she was sitting at home doing a puzzle when her doorbell rang. She looked out and saw Owen the wise owl. "What are you doing here?" said Sally to the owl. "Well, Sally I thought that I would talk to you a bit about what happened today", said the owl. "Do you know why the others weren't following you today?" said Owen. "Who cares" said Sally, "I didn't want to play anyway". "Well" said Owen "I'm going to tell you. They weren't following you because you were not being a good friend. They didn't like how you were treating them, so they decided that they would rather not play with you." "Yeah" said Sally "So if you're so wise, then what should I have done." "Sally, I'm going to tell you four things that are very important to being a good friend and getting along with others. First, you have to be polite, say please and thank-you. Second, you have to wait your turn. Third, you have to share. And fourth, you have to cooperate. During the game you were breaking all of the rules with your friends." "Whatever" said Sally "Now can you go, I have things to do."

For the next three days Sally didn't go and play with her friends, and she got very bored. Finally, she decided that she would go and try to follow the rules for being a good friend that Owen the Owl had told her about. Maybe then her friends would like her again and let her play with them. When she got there she noticed that Billy the Buffalo was leading the game. Instead of pushing him out of the way, she went to the back of the line and waited her turn. She played for awhile and then someone said "Sally it's your turn" She was polite and said "Thank-you very much". After the game, Perry the possum asked her if she wanted to come to his house for cookies.

Sally was so happy that her friends liked her again and decided that she was going to follow Owen the Owl's advice from now on.

- Activity: Yak Back.
- Check-out
- Mothers join for snack and games.[1]

Session Ten[1]

Saying goodbye.

- Check-in: Discuss that everyone who came to the group had seen fighting in their families.
- Read Book: "Franklin's Bad Day", and discuss with the children the feelings they are having about the group ending. Ask questions about the book, related to the feelings they are having as the group comes to an end.
- Craft: Complete the picture frames.
- Check-out: Tell each child what you will remember about them and how they were all special children. Go through the craft envelopes and have them take anything out that they do not want to take home
- Snack with mothers
- Presentation of certificates, "I am special" stars, and frames to the mothers.

THE FOLLOWING TWO SESSIONS WERE FOR THE CHILDREN'S GROUP ONLY.

Session Ten[2]

Families.

- Check-in: Ask the children what feelings they are having about group coming to an end. Go over all of the session topics that have been covered so far in group.
- Brainstorm and discuss different kinds of families (single mother, single father, visits with mother or dad, two parent, blended, re-married, lesbian/gay)

-Families change over time, and they may be different, but they are still a family.

-Discuss feelings about the children's current family situation.

- Activity: Have the children create a picture of their current family using the cutouts of people and feeling faces. While they are drawing, go around and ask each child if they had three wishes for their family what would they ask for. Have the children draw a picture of what their own family will look like when they grow up.
- Game: "Candyland": The children work together to get the playing piece around the game board. Along the way questions are asked about feelings, and what situations would make people feel certain feelings. Candy is shared as they move along to game board.
- Craft: Finish the picture frames that they will be giving to their mother's
- Game: "Wheel of Fortune" with puzzles asking questions about different kinds of families.
- Check-out: Tell the children that for the final session we will be celebrating by going to Ruckers and Dairy Queen.

Session Eleven[2]

Saying goodbye.

- Check-in: Have the children put their feeling arrow over the feelings they are having about group ending. Go through the craft envelopes and have them take anything out that they do not want to take home. Remind the children what the purpose of the group was, and ask them what they learned in the group, and what were some of their favorite parts of the group. Tell each child what you will remember about them and how they were all special children.
- Go to Ruckers and Dairy Queen
- Return to Elizabeth Hill and meet with their mothers. Present the children with their certificates of completion and their "I am special" stars, and have the children give their frames to their mothers.

Appendix B

Post Group Mother's / Caretaker's Evaluation

1. What did you like about your child's participation in the group?

   _____

   _____

   _____

2. How much do you think the group helped your child?

   A Lot A Little Not at All
   5 4 3 2 1

3. Have you noticed any change in your child as a result of participation in the group?

   Yes No

   If you answered yes, what changes did you notice? _____

   _____

4. How much information did you receive about what your child was learning and doing in the group?

   A Lot A Little Not at All
   5 4 3 2 1

5. What would you suggest that should be done differently in future groups?

   _____

   _____

   _____

Appendix C

Post Group Children's Evaluation

1. How much did you like the group?

A Lot		A Little		Not at All
5	4	3	2	1

2. What did you like about the group?

_____

_____

_____

2. What did you dislike about the group?

_____

_____

_____

3. How much did you learn in the group?

A Lot		A Little		Not at All
5	4	3	2	1

5. Would you tell a friend who has problems in her or his family to come to this kind of group? Yes No