CHILDREN EXPOSED TO PARENTAL VIOLENCE:

GROUP WORK AND INDIVIDUAL THERAPY

BY

JENNIFER CURTIS

A Practicum Report
Submitted to the Faculty of Graduate Studies
In partial Fulfillment of the Requirements
For the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba
December 2004

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

CHILREN EXPOSED TO PARENTAL VIOLENCE:

GROUP WORK AND INDIVIDUAL THERAPY

BY

JENNIFER CURTIS

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

MASTER OF SOCIAL WORK

ACKNOWLEDGMENTS

I am fortunate to have had such a brilliant committee. Diane Hiebert-Murphy, thank-you for accepting me as a student and providing me with guidance and support. Linda Perry, I learned so much from you. You have inspired me to continue practicing play therapy. Valerie Barnby, my friend and colleague, you are a role model to me. I value your perspective and insight.

I feel privileged to have worked together on this practicum with such amazing women. Heather Edinborough, your spirit, humour, and wisdom have been invaluable to me and the families we worked with. Julie Derocquigny, my co-leader, your energy and attention to detail contributed to the success of the children's group.

I am blessed to have such an amazing group of friends who supported me in both emotional and "technical" ways. I would like to thank Edith, Ray, Liisa, Claudia, Jacek, and especially Mark Fewster. I could not have completed this practicum without you.

I would also like to thank my family. Mom, you are my number one cheerleader and I love you for it. Dad, thank-you for your gentle encouragement, "isn't that thing done yet?!" Jill and Joe, thank-you for your long distance support and for "forcing" me to go on a much needed vacation. I also want to extend warm thoughts to my beautiful niece Lexie "Bean". I look forward to watching you grow and can hardly wait until you are old enough to enjoy a puppet show!

Garry, my partner and best friend, thank-you for living and breathing this practicum with me from start to finish. I am very lucky to have you in my life.

Finally, I am so grateful to the women and children who came to play with me. I will never forget you.

ABSTRACT

This practicum focused on six children between the ages of six and twelve years who had been exposed to parental violence. The majority were living in families headed by single-mothers, most of whom had secured safety for themselves in a women's shelter and for whom the violence had ceased between two months and seven years prior to referral. While the violence had stopped in these families, the women and their children were still struggling to cope in the aftermath of the violence.

The practicum included two interventions. A time-limited, structured, and closed group work approach was used with four of the children. The group included a support/parenting skills group for the mothers and a parent-child multi-family group for the mothers and children. The intervention incorporated Theraplay theory and activities as a means to strengthen the parent-child relationship. The other two children participated in structured, play based, individual therapy, where their caregivers were employed as partners in the therapeutic process. Outcomes for the children varied related to several factors such as the child's experience with the violence, resiliency factors, and the degree of parental support. A number of objectives were accomplished for both of these interventions however, as many of the children were able to communicate their feelings and experiences related to parental violence, experienced a therapeutic environment that was safe, fun and supportive, and became increasingly self-confident.

TABLE OF CONTENTS

Appendixes

LIST OF TABLES

CHAPTER ONE-PRACTICUM OVERVIEW

Introduction

Violence against women is now recognized as an important health and social problem that can have devastating consequences for families. Although women are the most obvious victims, it has become increasingly clear that the impact of this violence extends to children as well. In fact, current studies show that children who are exposed to violence between their parents are likely to experience detrimental effects with regard to their health, safety, behaviour, emotional and social development, and educational progress (Hughes, Graham-Bermann, & Gruber, 2001; Hughes & Luke, 1998). Some of these children will also develop post traumatic stress symptoms, feel responsible for the violence between their parents, and develop negative connotations about sex roles and the use of power in relationships. Without intervention, these children may continue the cycle of violence as perpetrators and possibly victims in their adult lives (Graham-Bermann & Levendosky, 1998; Rosenbaum & O'Leary, 1981). Although evidence continues to emerge documenting the adverse effects of witnessing parental violence on children (Edleson, 1999; Graham-Bermann & Levendosky, 1998), there is often little opportunity for these children to discuss their perceptions, worries and fears, or to get new information due to a shortage of intervention programs.

The potential serious consequences of family violence for children make this issue important in the practice of social work. Social workers are employed in a variety of settings such as hospitals, schools, counselling centres and child welfare agencies, and as such, they are likely to come into regular contact with children and

their mothers who have experienced violence in their homes. Children have the capacity to learn new skills in order to become resilient, and when social workers assist with the assessment and direction of that learning, children can grow to become productive, healthy individuals. Therefore, it is critical for social workers to be informed about the effects of violence on children and to be knowledgeable about effective treatment options as well as the factors which can promote healing.

This practicum was developed as a means of expanding the knowledge base in the area of parental violence and to enhance my own learning and skill base with respect to working with child witnesses. As such, this practicum offered a group therapy program as well as individual therapy to children who have been exposed to parental violence. The interventions, which incorporated Theraplay techniques and structured play activities, offered a supportive and safe environment for the children to identify and explore their reactions to violence in their families. Children's behavioural problems were also addressed as well as the more subtle symptoms related to their attitudes about violence and feelings of blame and responsibility. Additionally, because parental involvement is a critically important factor in a child's recovery from exposure to violence (Graham-Bermann & Hughes, 2003; Levendosky, 2000), caregivers were encouraged to participate in their children's healing process.

Objectives

The goals of this practicum were twofold. The first was to offer therapeutic services to children who had been exposed to parental violence, through the provision of group work and individual therapy. The second goal was to provide an opportunity for learning skills in intervening with children and families who have been affected by

domestic violence. Learning occurred through developing and facilitating a group for four children and through individual play therapy with two children and their caregivers.

Both a group intervention and an individual intervention were chosen to provide a wide range of skill development. A group offers a range of dynamics requiring different skills and intervention techniques than those required in individual work with children. Both of the interventions however, provided me with an opportunity to use play as a therapeutic technique with children and to further develop my knowledge and skill base in the area of play therapy.

The following are the educational and client-focused objectives which I hoped to achieve through engaging in individual and group interventions with children who had witnessed violence in their homes.

Client-Focused Objectives

1. To provide a fun and nurturing relational context for learning and resilience development.
2. To facilitate the identification and expression of feelings in children related to the violence they had witnessed.
3. To help children develop non-violent conflict resolution skills to be used in peer, family, and future relationships.
4. To enhance children's self-esteem by building on their strengths and inner resources.
5. To enhance children's safety and coping skills.

6. To help caregivers recognize and address the needs of children who had been exposed to violence.
7. To strengthen the parent-child relationship.

Personal Objectives

1. Increase knowledge about the impact on children of witnessing violence in the home. In particular, what are the effects of violence on children and what are the processes through which these effects occur.
2. To utilize content and process in both individual and group treatment formats to facilitate healing and expression of emotion with children who have lived in a context of secrecy and isolation.
3. To develop skills and understanding in comparing group and individual interventions and determining when and under what circumstances each intervention is most helpful to children.
4. To evaluate the efficacy of each intervention using qualitative and quantitative methods.
5. To become familiar with Theraplay and play therapy techniques and how they can be applied in individual and group contexts with children exposed to parental violence.
6. To provide a positive adult role model to children and their caregivers.

CHAPTER TWO-LITERATURE REVIEW

Introduction

After years of research, abuse in intimate partner relationships is now recognized as a significant social problem. Whether it is called *domestic violence*, *parental violence*, *partner abuse*, or *wife assault*, the dynamic involves an abuse of power perpetrated mainly by men against women in a relationship or after separation. It occurs when one partner attempts to dominate and control the other, through the use of physical and sexual violence, threats and intimidation, isolation, emotional abuse and/or economic deprivation. Although women are the most obvious victims, it has become increasingly clear that the impact of such violence extends to the children in these families as well.[1]

Children who have witnessed violence between adults in their home have been referred to as the "silent", "forgotten" or "unintended" victims of partner abuse (Elbow, 1982; Groves, Zukerman, Marans, & Cohen, 1993; Osofsky, 1998). These terms reflect the literature and practice which has been slow in recognizing the needs and problems of this population of children. Historically, the effects on children who witness violence have been minimized or attributed to other causes because the violence has not been seen as direct abuse of the children (Jaffe, Wilson, & Wolfe, 1990). It has become increasingly evident, however, that even if children have not experienced the abuse themselves, they are still intently attuned to the emotional and

---

[1] The term *parental violence* will be used to denote abuse of the female by her male partner, although it is acknowledged that these roles are sometimes reversed and that partner abuse can also occur in homosexual relationships. The term *parental violence* was chosen for use in this review as it most accurately captures the notion of the parent-child relationship which is of fundamental concern when exploring the impact

physical violence between their parents. While these children often show signs of trauma, in fact, parental violence has even broader implications because family relationships have such a profound influence on children's social, cognitive, emotional and behavioural development.

This literature review will focus on the needs of children exposed to parental violence by describing children's experiences within the violent home. It will also explore how exposure to parental violence can impair children's mastery of developmental tasks necessary for the establishment of their own well functioning, non-violent families. Conceptual frameworks within which these impacts are being understood will be presented as well as factors which will either bolster resiliency or increase risk for these children. Lastly, clinical implications will be discussed and assessment and intervention approaches will be examined. Areas of distortion in the parent-child relationship will be presented as possible points of intervention.

Defining Children's Exposure to Parental Violence

The literature uses different terminology when referring to children in households with parental violence, which perhaps reflects both a growing understanding of the issue, and the complexity and diversity of children's experiences. Most often, children from violent families have been referred to as either *witnesses* or *observers* of violence. These terms are now frequently being replaced by *exposure* to the violence, which is "more inclusive and does not make assumptions about the specific nature of the children's experiences with the violence" (Fantuzzo & Mohr, 1999, p. 22). Terms such as *experiencing, affected by*, and *living with* violence have

---

of violence on children and their families. The term *parents* is broadly construed to include married, common-law, or separated couples, stepparents, or dating partner.

also been found in the literature (Laing, 2000). These terms emphasize that children are not just passive onlookers in families where there is violence. They are actively involved in seeking to make meaning of their experiences and in dealing with the difficult and often traumatizing situations which confront them (Eisikovits & Winstok, 2001).[2]

Children's Experiences of Parental Violence

Exposure to parental violence implies a range of experiences for children. Children may directly observe physical assaults between their parents, overhear incidents from another room or see its aftermath in their mothers' physical injuries, or in her emotional response to the violence (Jaffe et al., 1990). Additionally, these children are vulnerable to other associated risks such as the possibility of being caught in the crossfire of violence (Roy, 1988), parental neglect or physical abuse (Fantuzzo & Lindquist, 1989; Hughes, Parkinson, & Vargo, 1989) and experiencing violence in adolescent or adult intimate relationships (Echlin & Marshall, 1995). Children also live with the effects of violence on the health and parenting capacity of their mothers and fathers. For example, violence has been associated with increased maternal depression and stress (Levendosky & Graham-Bermann, 2000), and paternal inconsistency, anger and irritability (Hughes, 1997; Peled, 2000).

Children may also be involved in the violence in ways which encourage a sense of responsibility for the violence (Jaffe et al., 1990). For example, the violent incident may occur in the context of arguments about the children, or the abuser may use the children to coerce the mother to return home. If the woman separates from her

---

[2] The terms *witnessing* and *exposure* will be used interchangeably throughout this review to refer to the experience of being exposed either directly or indirectly to

abusive partner, the children may live with the continuing fear that he will return and that the violence will start again. Additionally, after separation, violence may actually increase in severity and take on different forms through conflicts over child custody or visitation (Sudermann & Jaffe, 1998). In these situations, children may find that through issues of contact arrangements, they move from the periphery to the centre of the conflict (Sudermann & Jaffe, 1998).

In homes with parental violence, the abuser often enforces a code of secrecy as a means of controlling family members. Children are taught not to tell about the abuse, and this often prevents them from discussing the violence with their peers and reaching out to adults for help or support (Peled, 1997; Pressman, 1989). If the secret of the violence is disclosed, children may then experience the effects of interventions, such as the involvement of the police, or movement to a shelter. These sudden changes can bring with them disruption of schooling and significant losses, such as friends, pets, toys, surroundings, and activities (Edleson, 1999; Jaffe et al., 1990).

Any definition of witnessing violence must include these direct and indirect ways in which children experience violence. Children may see the violence or be used as a part of it, but more often they may hear the violent event and experience its aftermath. The unique and salient characteristic of this exposure is that children observe their parents as both perpetrators and victims of violence. Violence occurs within their core relationships, and its significance for children lies in that fact (Wolak & Finkelhor, 1998).

---

parental violence.

Prevalence

Statistics Canada (2001) has produced a comprehensive survey about violence against women that includes estimates about the number of children who witness violence at home. From the initial survey, it was reported that 29% of all Canadian women experienced physical or sexual violence at the hands of an intimate partner (Statistics Canada, 2001). Almost 4 in 10 women (39%) reported that their children witnessed the violence, which would mean that at least two million children have been exposed to violence (Statistics Canada, 2001). More than 1.2 million of these children have witnessed extreme forms of violence, including physical injury, and in most of the cases, the mother feared for her life (Statistics Canada, 2001). These figures represent an underestimate of the real prevalence, given that parents tend to underestimate what children have been exposed to in their homes and, even in cases where children may not have been eye witnesses to an assault, they are still affected by the climate of fear in their family and the impact of violence on their mother (Jaffe et al., 1990).

The Violent Family

The literature suggests that parental violence is most likely to occur in chaotic families characterized by rigid sex role expectations, dominance hierarchy, high levels of conflict and disorganization, poor communication patterns, secrecy, and social isolation (Barnett, Miller-Perrin, & Perrin, 1997; Elbow, 1982). Poverty, job instability, and family stress are also commonly present in violent homes (Osofsky, 1999). In addition, there is some evidence that parenting quality suffers in families where women are abused (Levendosky & Graham-Bermann, 2000). Consequently,

children who are exposed to the violence often will not get their emotional or developmental needs met because the home environment does not offer nurturance, support, structure, or supervision (Elbow, 1982). Children are therefore affected not only from exposure to frightening and emotional scenes involving parents, but also from the toll of the parents' abilities to maintain close and positive parent-child relationships.

To understand why and how children who witness violence are at risk socially, emotionally, and physically, the dynamics of the violent relationship and the effects of such violence on men and women, both as individuals and as parents, should be considered.

Abused Women

Domestic violence can have serious consequences for female victims in terms of their physical and emotional health, as well as their overall quality of life (Holtzworth-Munroe, Smutzler, & Sandin, 1997; Jaffe et al., 1990). In addition to injuries caused by the abuse, they may suffer from stress-related illnesses, chronic pain, post traumatic stress disorder, depression or anxiety (Levendosky & Graham-Bermann, 1998). Women in violent relationships also tend to be extremely isolated and they may use alcohol and/or drugs to cope with the physical and emotional pain (Jaffe et al., 1990; Levendosky & Graham-Bermann, 1998). The impact of violence on women can be further exacerbated by a lack of economic or social resources (Straus, Gelles, & Steinmetz, 1980) and/or a history of victimization due to physical, sexual and emotional abuse in their families of origins (Jaffe et al., 1990).

For some women, experiences of discrimination, racism, and poverty create additional barriers for obtaining support and ending the abuse (Dutton, 1996). These women often must cope not only with the consequences of being abused but also with the effects of their marginalized position in society, and the reality of limited services. Despite the impact of abuse on women, most recognize that the abuse they suffer has a detrimental impact on their children, and in fact such concerns are a significant factor in women's eventual decisions to end their relationship, often after trying to stay together for the sake of the children (Levendosky, 2000).

Abused Women as Mothers

Experiencing violence has direct implications for a female victim's role as a mother (Holden, Stein, Ritchie, Harris, & Jouriles, 1998; Levendosky & Graham-Bermann, 2000). First, many abused women were witness to parental violence or else direct victims of violence in their family of origin (Jaffe et al., 1990). Therefore, many of these women have had extremely poor models of parenting. They were inadequately nurtured as children and do not know how to parent effectively. Secondly, the context of parental violence influences the behaviour of the child, thus creating additional parenting stress for their mothers. For instance, Sullivan, Nguyen, Allen, Bybee, and Juran (2000) noted that children who have witnessed the devaluation of their mother as a parent by their father tend to disregard her attempts to discipline them. Finally, the overwhelming personal needs of the women as victims of abuse can impact on their ability to be emotionally and physically available to their children (Levendosky, 2000). Indeed, it is easy to see how the impact of violence,

with all the attendant chaos and trauma, can affect a woman's coping skills and potentially compromise the mother-child relationship.

Abusive Men

Abusive behaviour by men has been strongly linked with what they experienced and learned as children. In particular, many of these men have childhood histories of physical abuse and witnessing violence perpetrated by their fathers (Rosenbaum & O'Leary, 1981). From these early experiences, many men have learned that violence is a method which can be used to secure power and control in the family and in order to do so, they create an atmosphere in which their female partners are isolated, secrecy is maintained, and fear and intimidation permeate the family (Peled, 2000). Men who abuse characteristically lack the verbal skills to negotiate conflict, have poor impulse control and a rigid style of demanding and controlling behaviour (Peled, 2000). In addition, these men tend to have low self-esteem, traditional beliefs, difficulty in expressing emotions, lack assertiveness, have employment problems, struggle with jealousy, have authoritarian personalities, are irritable, and are insecure (Pagelow, 1984; Peled, 2000). Excessive or frequent alcohol use by these men can also be a problem. In and of itself, alcohol abuse can increase the number of crises that require police intervention and can exacerbate the level of stress, fear, and disorganization in the family (Peled, 2000). Treatment efforts with abusive men aimed at stopping violence through changing attitudes and behaviours, are often hampered because this population of men tend to deny their violent acts, blame their victims for provoking the violence, or simply refuse to co-operate (Pagelow, 1984).

Abusive Men as Fathers

It seems likely that children who witness violence between their parents would be affected by their father's actions, yet little is known about the nature of fathering in violent homes due to a lack of research studies (Peled, 2000). One exception is Holden and Ritchie's (1991) study, which reported that a significant predictor of behaviour problems in children of abused women is their exposure to paternal anger and irritability. They also found that compared to fathers in a control group, fathers in violent families did less child care, were angry at their children more often, were less affectionate, were less likely to reason with their children, and were more likely to physically discipline them. In this study, the data regarding the male perpetrators was collected from their previously abused female victims, thus some caution needs to be exercised when interpreting its results. Nonetheless, it is logical to assume that a father who is concerned with maintaining family control through intimidation, isolation, and assaultive behaviour would have difficulty employing positive parenting skills such as empathy, support, and consistency.

Research on the Effects of Exposure to Parental Violence on Children

It has only been since the early 1980's that researchers have investigated the influence of witnessing parental violence directly by studying the children of abused women. Much of the early literature on the effects of parental violence on children is based upon anecdotal reports from shelter staff and other professionals whose work exposed them to children from violent homes. These studies have described child witnesses as a heterogeneous population, displaying such symptoms as aggression, withdrawal, anxiety, and social inadequacy (Edleson, 1999; Sternberg et al, 1993).

More recent research has contributed empirical data to the knowledge base by using standardized measures and control groups to compare children of abused women to children from non-violent families (Ezell, McDonald, & Jouriles, 2000). In addition, researchers have called for an inclusion of more qualitative components in these quantitative studies (Graham-Bermann, 2000), with a view of obtaining more detailed descriptions of children's experiences, beliefs, and attitudes.

The major area of focus in the studies of children of abused women to date has been on child adjustment. Studies have examined various aspects of adjustment, including behaviour problems, social adjustment, self-esteem, and child attitudes and attributions. Some results have been contradictory, but overall there seems to be a clear negative impact for most children exposed to parental violence (Edleson, 1999; Hughes & Graham-Bermann, 1998; Hughes & Barad, 1983).

Behavioural and Emotional Functioning

Some studies have not found significant behavioural differences between children who have and have not witnessed violence (Rosenbaum & O'Leary, 1981; Wolfe, Zak, Wilson, & Jaffe, 1986). Others have found a positive correlation between amount of violence or conflict in a family and child behaviour problems (Jaffe, Wolfe, Wilson, & Zak, 1986). When these differences have been found between children from violent and non-violent homes, the children from violent homes have exhibited more internalizing (e.g., anxiety, depression), as well as externalizing (e.g., aggression, running away) behaviour problems. In addition, children of abused women fall above the clinical cut-off scores on the Child Behaviour Checklist (Achenbach, 1991) in higher than average percentages (Ezell et al., 2000). Studies

show that 25-65% of these children have behaviour problems within the clinical range, indicating a need for intervention (Graham-Bermann, 1998).

Social Competence and Adjustment

Many studies have used the Social Competence score from the Child Behavior Checklist (Achenbach, 1991) as a measure of social adjustment. This score includes the parent's report of the child's involvement in and proficiency in activities, social contacts, and school. Overall, findings have indicated that children of abused women, especially the residents of women's shelter, have significantly lower social competence skills than comparison groups (Fantuzzo et al., 1991; Jaffe, Wilson, & Wolfe, 1986; Wolfe, Jaffe, Wilson, & Zak, 1985; Wolfe et al., 1986). For example, a study by Fantuzzo et al. (1991) concluded that children who had been exposed to violence in their homes had the lowest levels of social functioning when compared to children their own age.

Other researchers have investigated social problem solving skills in children as a measure of social adjustment. Because of the influence of social learning theory and modelling of aggression, children of abused women are likely to have observed and learned that violence is a means of resolving interpersonal conflicts. For example, Rosenberg (1984) (cited in Jaffe et al., 1990) found that children of abused women did less well on a measure of interpersonal sensitivity, with greater difficulty identifying problem situations and understanding the thoughts and feelings of others. In addition, the children in her study chose more passive and/or aggressive strategies for resolving interpersonal conflicts rather than assertive ones.

While peer relationships of children of abused women have not been studied directly, Moore and colleagues (1990) provide an interesting theoretical discussion of this topic. It is thought that since children of abused mothers often exhibit aggressive behaviour towards their peers, this would lead to higher rates of peer rejection. In addition, since it has been found that children who experience family violence exhibit internalizing behaviour problems as well, this may lead to withdrawal from social interaction from peers.

Self-Esteem

There has been little empirical research investigating the extent to which child witnesses suffer from poor self-esteem, and the few studies which have been conducted have contradictory results. Hughes and colleagues included measures of self-esteem in their studies of child adjustment. Findings indicated that child witnesses to parental violence display significantly lower levels of self-esteem than comparison children (Hughes, 1988). Other results have been less clinically significant, although means for witness groups have been below the normative average (Hughes & Barad, 1982), suggesting that despite the variability, children who have been exposed to violence do suffer from lower self-concepts than children from non-violent families.

Beliefs and Attitudes

Children's beliefs and attitudes about the violence they observe have also been studied (Jaffe, Hurley, & Wolfe, 1990; Jaffe et al., 1986; Jaffe, Wilson, & Wolfe, 1988). If children learn that violence is an acceptable way to resolve interpersonal conflict, they may be more likely to tolerate or perpetuate violence in future

relationships. In order to develop effective interventions that can influence these attitudes, researchers need to have a clearer understanding of what the attitudes are and how they work.

The approach to studying beliefs and attitudes has been through child interviews. Jaffe and colleagues (1988) constructed the Child Witness to Violence Interview, which inquires about children's attitudes and responses to anger, knowledge of safety skills, and feelings of responsibility for violence between their parents. While there was no difference in attribution of responsibility for parental violence, the authors found that children of abused women were more likely to report condoning and using violence as a means of conflict resolution and had less knowledge and skills in dealing with violent situations. Jaffe et al. (1988) stated that this finding is especially alarming since many of these children will have to face ongoing crisis in their lives that will involve their personal safety. In some cases, children may know what to do to get help, but because they have been previously frustrated trying to get help, they feel a sense of hopelessness. In other cases, children resist taking action because they have divided loyalties between their mother and their father (Jaffe et al., 1990). The results of this study indicate that the development of psychoeducational interventions for these children is an important need. Jaffe et al. (1990) believe that early intervention should focus on children's attitudes about aggression and family behaviour, in order to end the intergenerational transmission of violence.

Long Term Effects

Although some problems that children develop in response to exposure to parental violence constitute immediate reactions to difficult situations, there is an increased risk that these children will develop behavioural and psychological problems that could extend into adulthood (Rossman, 2001). In their study of the effects of parental violence on adults, Silvern, Karyl, and Landis (1995) found that witnessing violence as a child was correlated with adult depression, trauma-related symptoms, and low self-esteem among women and trauma-related symptoms among men. They concluded that witnessing violence appeared to account for these effects, independent of the other adverse influences present in the home, such as alcohol abuse and divorce. In another study, Straus (1992) found that witnessing parental violence as a teenager led to an increase in symptoms of depression and problems with substance abuse in adulthood.

Children who are exposed to violence may also become involved in violent relationships as adults, either as victims or as perpetrators (Rossman, 2001). At an early age, from watching their parents' interactions, boys can learn that men are dominant and powerful, while women are submissive and inferior. In addition, girls who witness violence may tolerate abuse in their own intimate relationships, because they have internalized abuse as normative behaviour among families. Straus et al. (1980) found that when compared to men who did not witness parental violence, men who did are three times more likely to physically abuse their female partners. In another study of women residing in shelters, as many as 80% of the women recalled their father physically assaulting their mother (Tomkins et al., 1994). Thus, children

who reside in homes with parental violence are at risk for a variety of adjustment problems during adulthood.

Theoretical Perspectives

The research concerning exposure to parental violence as a risk factor for children's maladjustment stems from the general premise that children's behaviour can best be understood in the context of important relationships. However, the problem of children's exposure to parental violence is a complex issue, and as such there have been several models proposed to explain the link between parental violence and child adjustment. Observational learning and modelling of aggressive behaviour is one direct mechanism through which children can acquire externalizing behaviours. Another mechanism through which children's adjustment may be influenced is the direct effect of traumatic stress. Additionally, children's adjustment may be related to the quality of their relationship with their primary caregiver.

Modelling Effects

Children of abused women may be at risk of developing emotional and behavioural problems because of the learning opportunities associated with parental violence. Specifically, witnessing violence in the context of the family will teach children that violence is an extremely powerful and effective means of control, and that women and children are both legitimate and deserving victims. This may be problematic for children in current relationships, leading to the expression of externalizing/aggressive behaviour problems and difficulty in peer relationships. Additionally, modelling parental violence may cause children difficulty as adults in future relationships if they continue the pattern of problem solving through violence

that they have witnessed from their parents (Jaffe et al., 1986; Jaffe et al., 1990; Straus et al., 1980).

Social learning theory (Bandura, 1977) emphasizes the importance of imitation and observational learning in children's development. This means that children do what they see others doing, as well as learn by simply observing the behaviour of others. Parents are the most influential models children have, thus it makes sense that witnessing parental violence could shape the behaviour of the children as they grow up. It has been found that the aggressive behaviour of the abuser is more likely to be imitated than the helpless behaviour of the victim (Jaffe et al., 1990), as children tend to identify with the more powerful model. While aggression is often modelled by both girls and boys (Jaffe et al., 1990), the identification may be stronger for boys due to gender role identification with the male model (Porter & O'Leary, 1980).

The idea that children will imitate aggressive behaviour is not a new one. Research on the effects of children viewing television violence dates back to the inception of television. There has been support for a relationship between viewing violence in the media and behaving violently (Jaffe et al., 1990). However, the connection has been overlooked for children observing violence in their own homes, where one might expect that it can be ever more salient and influential.

Further evidence for the mechanism of modelling is provided by retrospective accounts of abusers and their victims. For example, men and women involved in violent relationships are more likely than other to have witnessed violence between their parents when they were children (Rosenbaum & O'Leary, 1981). Roy (1977) reported that in her sample, 81% of the abusive men and 33% of the abused women

reported some violence in their families or origin. In a nationwide survey, it was found that men who witnessed violence between their parents as children were 1,000 times more likely to abuse their partner as adults (Straus et al., 1980).

In summary, we know that parents are very influential behavioural models for their children, thus making social learning theory a useful model for explaining how witnessing parental violence can influence children as they grow and develop. However, this theory does not explain why only some children will imitate what they have learned from their parents. Furthermore, the theory is limited in the sense that it fails to explain how other problems develop in children, for example, post traumatic stress symptoms, depression and low self-esteem. Clearly, social learning theory cannot fully explain the relationship between children's witnessing domestic violence and their subsequent development. This points to the need for more research on the variables that might mediate this relationship.

Trauma Effects

The framework of psychological trauma provides another way of understanding the impact of parental violence on children. Post-traumatic stress refers to the reactions of individuals who witness or directly experience life-threatening events (Arroyo & Eth, 1995). There are two types of post-traumatic stress, one of which occurs in the aftermath of an isolated, but very disturbing incident. The second, more serious type occurs when an individual is repeatedly exposed to traumatic events. Silvern et al. (1995) point out that witnessing others being severely endangered or injured can be as traumatic as being directly victimized oneself, particularly when violence is directed toward a parent upon whom the child relies for

caretaking and protection. These authors note that, "such conditions profoundly violate expectations about the safety and goodness of the world" (p. 44). Clearly, the latter, most serious form of psychic trauma is applicable to child witnesses of violence whose mothers are the targets of constant, often extreme, physical and emotional abuse.

Trauma in childhood is thought to create harm because it overwhelms the child's developing sense of self and coping mechanisms (Arroyo & Eth, 1995). Children who are exposed to traumatic events cannot calm themselves or cognitively process the experience, which can lead to complex traumatic reactions and symptoms. Feelings of helplessness, fear, and a state of constant arousal are the daily burden of children exposed to parental violence, and it is these characteristics that are the crux of trauma (Silvern & Kaersvang, 1989). As a result, many children exposed to partner abuse develop post-traumatic stress disorder (PTSD), a diagnostic category that includes a number of symptoms related to psychic trauma. According to the American Psychiatric Association (APA), (as published in its Diagnostic and Statistical Manual of Mental disorders (1994) [DSM IV-R]), the disorder may have an onset at any age following exposure to a psychologically traumatic event that is generally outside the range of typical human experience (Arroyo & Eth, 1995). Additionally, the DSM-IV-R outlines that the main symptoms of PTSD include hyperarousal (such as difficulty sleeping, loss of appetite, exaggerated startle reactions and difficulty concentrating), avoidance (withdrawal from activities or places, emotional constriction), and re-experiencing (such as recurring dreams, post-traumatic play or other types of preoccupation with the trauma) (APA, 1994). Overall, the trauma-based body of

literature postulates that children who are exposed to the abuse of their mothers are exposed to a significant stressor that can produce symptoms of distress.

Empirical research has supported the presence of post-traumatic stress symptomotology among child witnesses. For example, children who witness the murder or rape of their mothers exhibit substantial evidence of psychological trauma (Pynoos & Eth, 1984). In another small study, half of a sample of 20 child witnesses residing at a women's shelter reported "severe" post-traumatic stress disorder (Silvern et al., 1995). Silvern and her colleagues (1995) also found in a retrospective study of university students that reports of parental violence were associated with high levels of current, adult post-traumatic stress symptoms, suggesting that such symptoms may also extend into adulthood. Given that traumatic reactions are a reality for many children in this population and because of the potential for these symptoms to progress as the child grows and develops, early intervention is critical as it can assist children to develop adaptive coping skills before the effects of trauma become entrenched (Kerig, Fedorowicz, Brown, & Warren, 2000).

Parenting/Attachment Effects

Attachment theory offers a useful framework for exploring how violence can undermine a parent's ability to secure a close and positive relationship with their child. Attachment, often defined as a "reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver" (James, 1994, p. 2), is a developmental task that confronts children in the first few years of their life. John Bowlby (1973) first studied attachment in children and his research revealed the importance of a secure attachment relationship with a primary caregiver, usually the child's mother,

for later healthy functioning. Attachment status reflects the balance between a child's willingness to explore, and the need to stay close to a mother/caregiver following a short separation from her (Ainsworth, 1973). The development of secure attachments is a key task of the infant, toddler, and preschool periods, and insecure attachment is a risk factor for later emotional and behavioural problems (Gewirtz & Edleson, 2004).

A secure attachment provides the foundation for the child's growth whereby infants can use their "mother as a secure base from which (they) can venture forth and explore the world" (Ainsworth, 1973, p. 80). Throughout the child's development, this early secure attachment contributes to healthy personality traits such as the establishment of trust, the capacity for intimacy, and a sense of self-worth (Levy & Orlans, 1998). Securely attached children also expect others to work from similar foundations of self-esteem, which makes it easier for them to maintain healthy relationships. Furthermore, they tend to think logically and perceptively, which allows them to maximize their intellectual potential and to develop strong consciences (Levy & Orlans, 1998). Because their lives have continuity and meaning, securely attached children feel able to count on the predictability of people, things, and events, which makes them more likely to develop the internal and external resources needed to cope with stress, frustration, and anxiety (Levy & Orlans, 1998). Predictably, they also seem to rebound from trauma more fully than do children without strong attachments (James, 1994; Levy & Orlans, 1998). According to Bowlby (1980) there are two parental variables that are strongly related to the development of a secure attachment. The first is responsiveness to the child's signals of his or her feelings and needs. The second is mutually enjoyable interactions between a parent and child. Thus, the

development of a secure attachment relationship in infancy provides a solid foundation for the development of the child's sense of self, sense of the world, and sense of relationships with others.

Disruptions in a child's attachment can develop if children perceive their primary caretakers as unavailable and unresponsive to their needs (Gewirtz & Edleson, 2004; Levy & Orlans, 1998). Therefore, children who have been exposed to violence in their families can be at risk for attachment disturbance and related behavioural and emotional problems. Parental violence can compromise the parent-child attachment in many ways. First, disruptions in normal routines around sleep time and feeding are likely to occur given the unpredictable and disorganized home environment (Gewirtz, & Edleson, 2004). Second, the mother may be distracted by concerns of basic safety and therefore not have the energy to respond to her child's physical or emotional needs (Bilinkoff, 1995; Jaffe et al., 1990; Wolfe et al., 1985). Third, the father-figure may lack the ability to empathize with his children (Mathews, 1995; Peled, 2000), and as a result he may be unable to offer support and encouragement as his violent outbursts model unhealthy methods of relieving stress.

Given the above dynamics, children exposed to violence are at risk of seeing themselves as unlovable, unwanted, and unworthy (Levy & Orlans, 1998). They may show little interest for normal pleasures and exploration or they may not play well or initiate positive interactions. Those who reach out to such children may find themselves frustrated because it can be so difficult to engage them, and eventually they may give up trying to reach out. As a result, when these children encounter future difficulties or problems, they may not trust that others will help them or else

they expect others to become impatient with them. The environmental context of parental violence, therefore, can be a barrier to the formation of healthy attachments for children and thus create ongoing obstacles to the development of healthy relationships and coping skills.

Developmental Psychopathology Framework

The three models described above offer important contributions to understanding developmental outcomes in children exposed to violence. However, these models emphasize a linear cause and effect explanation for the impact of parental violence on children, and on their own they are inadequate in explaining the wide range of behaviours that children exposed to violence present with. In addition, these model fail to explain why many children who witness violence do not demonstrate adverse impacts. As a result, researchers have moved towards a model of developmental psychopathology which focuses on the interaction of risk and protective factors that mediate the impact of exposure to parental violence on children (Gewirtz & Edleson, 2004; Graham-Bermann & Hughes, 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). This model offers a useful framework for understanding children's exposure to parental violence as a risk factor for future developmental problems.

According to the developmental psychopathology perspective a child's adaptive functioning results from a complex interplay among individual, physical, and mental capacities, developmental stage, and external factors in the social and physical environment (Wolfe et al., 2003). The importance and complexity of family, social, and cultural factors are acknowledged in predicting and understanding developmental

changes and negative outcomes in children, and single variable causes are held to greater scrutiny (Wolfe et al., 2003). In contrast to linear cause and effect models, the developmental psychopathology framework adopts a broader view of the forces at play in shaping children's responses to violence and considers how children adapt to the direct and indirect violence occurring in their homes.

Important in a developmental psychopathology framework is the notion that there are many risk and protective factors that are present for children and it is the interaction of these factors that affect children's development (Gewirtz & Edleson, 2004). Risk factors are variables that are associated with an increased likelihood of poor physical, emotional, and behavioural outcomes. Examples of risk factors for children include premature birth, conduct problems, parental mental illness or substance misuse, physical abuse, exposure to violence, homelessness, and poverty (Gewirtz & Edleson, 2004). It is believed that risks of a chronic, rather than acute nature, as well as multiple risk factors, are more likely to have damaging long-term effects for children (Gewirtz & Edleson, 2004). Exposure to domestic violence may frequently co-occur with other risk factors such as poverty and other types of violence such as child maltreatment and community violence (Gewirtz & Edleson, 2004; Wolfe et al., 2004). This makes the unique effects of exposure to parental violence difficult to separate from those of other risks in a child's life.

Protective factors, on the other hand, are those variables that buffer children from adversity. Research on protective factors originated with longitudinal studies of high-risk youth who, despite the odds, matured and adapted successfully (Garmezy & Masten, 1994; Werner & Smith, 1982). Examples of protective factors include

individual factors, such as the child's positive temperament, intellectual capacity, and social competence; family or interpersonal factors, such as caring adults, secure attachments to caregivers, and strong relationships with others; and cultural, ethnic, or community factors, such as living in a supportive, safe community (Gewirtz & Edleson, 2004; Wolfe et al., 2003).

Risk factors act both directly and indirectly to render children vulnerable to poor developmental outcomes, and the relationship between risk factors and outcome may be affected by specific aspects of the child's environment (Wolfe et al., 2003). Similarly, protective factors may act directly to protect children from poor outcomes; they may also ameliorate the impact that violence exposure has on a child's functioning (Wolfe et al., 2003). For example, since parental violence occurs in the home, we may expect that additional variables, such as parenting, the home environment, and social support will influence how exposure to domestic violence affects children. Therefore, positive attachments, an extended family or the additional supports of educational or counselling opportunities may act to protect a child from potentially grave outcomes related to parental violence in the home.

Research on risk, resilience, and protective factors offers a framework for answering questions about the potential negative effects of domestic violence on child functioning and how children might be protected from them. This practicum examines the impact on children of exposure to parental violence through a developmental lens focusing on risk and resilience. What follows is a more detailed discussion of the moderating variables and resiliency factors that can influence developmental outcomes for children exposed to parental violence.

Moderator Variables of Child Adjustment

Multiple factors have been suggested to moderate child adjustment such as severity of violence witnessed, duration of witnessing, and compensatory factors such as a supportive relationship with the mother or other family members, and strengths such as school or social skills (Graham-Bermann & Hughes, 2003; Wolfe et al., 2003). Age, gender and developmental level are also important variables for determining the effect of violence on children and their mode of reaction (Graham-Bermann & Hughes, 2003; Wolfe et al., 2003), and they will be discussed below.

Age and Developmental Level

Children's levels of understanding and coping abilities differ with age, which suggests that the impact of exposure to violence cannot be assessed without considering a child's developmental level (Graham-Bermann & Hughes, 2003). For example, younger children may be more vulnerable to trauma than older children given that older children are more capable of coping with new stressors as they possess a foundation of internal and external resources that have been acquired through experience (Jaffe et al., 1990). Thus, age as a variable determining children's reactions to parental violence is linked with their levels of development.

Although little research has explored the impact of abuse on pregnant women, Jamieson and Hart (1999) reported that women abused in pregnancy are more likely than other abused women to disclose that they experienced "very serious" violence, defined as beatings, choking, gun/knife threats and sexual assaults. Some impacts of violence during pregnancy such as premature labour and delivery, foetal death and direct foetal injury can be attributed to trauma while others, such as substance abuse and failure to obtain adequate nutrition, rest and medical care, are due to the stress of

living with abuse (Jamieson & Hart, 1999). Thus, it is possible that some children are affected by parental violence by being harmed before birth when their mother is assaulted.

Infants are also particularly vulnerable to the effects of parental violence. The care of the infant and development of the mother/child relationship may be compromised because of the abuse experienced in this period. Infants are aware of the emotional states of others at an early age, and they may be disturbed by the anger and chaos of a violent household (Sudermann & Jaffe, 1998). Moreover, infants require consistency and nurturing by sensitive, responsive caretakers, but mothers in abusive relationships may be too injured or under too much stress to respond to their infants' distress or to give them the intense, structured physical care they need. As a result, some infants from violent homes may show signs of health problems and neglect. They may be underweight, have problems eating and sleeping, cry inconsolably, and be unresponsive to adults (Jaffe et al., 1990). Not only will this affect their physical health, but children may also encounter difficulty in establishing basic trust as a result of their parent's distance and unavailability. Also, by virtue of their small size, and because of the time they spend in their mother's arms or near her, infants are at risk of being injured when there is violence in the home (Jaffe et al., 1990). Furthermore, because infants have not developed the verbal ability to communicate their needs, they cannot access resources outside of the family (McAlister Groves, 1991).

Toddlers and pre-school children are dependent on their parents to help them manage their emotions and behaviour (Sudermann & Jaffe, 1998). Children of this age may become increasingly aware of, and disturbed by, the chaotic atmosphere

generated by parental violence. They lack the resources to cope with confusing and frightening events on their own and are particularly dependent on parents for explanations and reassurance (Jaffe et al., 1990). Because they are too immature to regulate their own behavioural and emotional responses without parental assistance, they tend to show signs of behavioural and emotional problems if their mothers are too depressed or otherwise incapacitated to provide responsive care (Davies, 1991). As they get older, they also begin to think about and try to understand the things that go on around them. Young children who have observed the abuse of their mother need to talk about their experiences with adults who can help them explain and clarify what they have seen. If the children cannot do this, they may try to express themselves by acting out (Davies, 1991). Some researchers believe that pre-school children are especially likely to feel responsible for the violence between their parents because of their developmental stage which is characterized by egocentrism and an inability to view things from the perspectives of others (Jaffe et al., 1990).

School-age children face the developmental challenges of adapting to the school environment and establishing relationships with peers. These tasks require the ability to regulate emotions, demonstrate empathy, and process sophisticated cognitive material (Margolin & Gordis, 2000). Such tasks are best supported by safe, secure relationships with parents. Yet, children who witness violence in their homes lack this feeling of safety and instead live with fear and anxiety in anticipation of the next violent incident (Jaffe et al., 1990). While school-aged children broaden their social circle during this stage, they are still very oriented within their families, and tend to view their parents as role models (Jaffe et al., 1990). Because of this they may feel a

sense of confusion and divided loyalty. For instance, they may want to protect their mother from harm, yet feel angry with her for behaving passively. Similarly, they may fear their father, yet respect his power and control of the family. Children of this age also worry about the vulnerability of their mothers and siblings and may try to intervene in various ways to stop the abuse (Jaffe et al., 1990).

Behaviour problems resulting from exposure to violence may become apparent as children enter school and start interacting with peers and teachers. Aggressive behaviour is often a particular concern, but children may also act out, have conduct problems, and be emotionally needy, fearful, and anxious (Jaffe et al., 1986; Rosenbaum & O'Leary, 1981). They may have academic problems (Margolin & Gordis, 2000), difficulties with peers, and experience sadness, depression, and low self-esteem (Hughes, 1988; Jaffe et al., 1986). Isolation may also be a problem. In some cases, children are ashamed of their homes and concerned about keeping the violence a secret. In other cases, children may be isolated by an authoritarian father figure who seeks to control the family by limiting access to outside influences (Jaffe et al., 1990).

The developmental stage of adolescence is characterized by increased independence, the development of empathy and problem solving skills, and an appreciation for what they can and cannot control (Carlson, 1990). Accordingly, adolescents tend to be able to view the violence in their homes as their parents' problem and to turn to friends and adults outside their families for support. They may be less fearful and anxious about the situation than younger children and less likely to feel responsible for the violence (Jaffe et al., 1990). Some teenagers, however, will

have lived with the abuse for many years and may demonstrate long-term effects. Children who have grown up with violence are more prone than other adolescents to act out their anger and frustration in ways that result in delinquencies and involvement by the criminal justice system (Wilson & Martin, 1997). These adolescents may assault peers, siblings, and even parents. Some may use alcohol or other drugs to cope with their problems, or they may escape their situation by running away (Jaffe et al., 1990). Suicide is also a concern with troubled youth, particularly those who are withdrawn and depressed (Carlson, 1990). Although some adolescents from families with parental violence find ways to manage and escape, others stay at home and assume parenting duties for younger children in the household. This pattern of role reversal results in the adolescent having significant responsibilities (Jaffe et al., 1990), outside the realm of what would be considered appropriate for their age and developmental stage.

Adolescence is also a stage where children begin to develop intimate relationships outside their families and can practice communication and behaviour patterns that they have learned from their parents. Following their parental role models, adolescent males may use intimidation and physical force within their own dating relationships, while adolescent girls may start to accept threats and violence from boyfriends (Jaffe et al., 1990). Although Rosenbaum and O'Leary (1981) point out that female victimization is not necessarily correlated with a history of parental violence, nonetheless, intervention is needed to stem any possibility of repetition of the cycle.

Gender Differences

Gender differences with respect to the extent or types of problems exhibited by children who are exposed to partner violence have been considered in the literature. Some findings indicate that boys are more likely to exhibit externalizing symptoms than girls who are more likely to react with internalizing problems (Graham-Bermann & Hughes, 2003). Jouriles and Norwood (1995) noted that boys were more at risk for physical child abuse than were girls in families with domestic violence. Graham-Bermann and Brescoll (2000) studied the ways in which parental violence affected children's stereotypes of gender, power, and violence, and found that boys and younger children held more distorted beliefs about the family and the acceptability of violence than did girls or older children. Some researchers have hypothesized that these gender-specific behaviours are precursors to the intergenerational transmission of violence (Jaffe et al., 1990) and therefore recommend early intervention for this population of children.

Resiliency in Children

The concept of resilience refers to "the capacity to spring back, rebound, successfully adapt in the face of adversity, and develop social competence despite exposure to severe stress" (Rivkin & Hoopman, 1991, p. 1). Understanding how exposure to parental violence affects children and what enables them to cope can point to important considerations when trying to intervene with children. (Hughes et al., 2001). Hughes et al. (2001) found that there are three categories of protective factors associated with resilience. The resilience triad is composed of individual

characteristics of the child, the quality of family support, and the quality of extrafamilial support.

Various individual characteristics have been associated with increased resilience among children exposed to parental violence, enabling them to use their own internal resources effectively as well as reach out to others for support when needed. Resilient children have been found to display characteristics such as intelligence, sense of humour, and effective problem-solving abilities (Gewirtz & Edleson, 2004; Hughes et al., 2001; Wolfe et al., 2003). Children's degree of resilience will also be influenced by their ability to tolerate frustration, manage feelings of anxiety, and ask for help when needed (Gewirtz & Edleson, 2004). Additional protective factors cited in studies include feelings of positive self-esteem and self-efficacy, attractiveness to others in personality and appearance, individual talents, and confidence (Gewirtz & Edleson, 2004; Hughes et al., 2001). Such qualities tend to elicit more positive responses from others and facilitate coping strategies and problem solving skills. Resilient children also have a strong sense of self-control, take responsibility for their behaviour, and exercise self-discipline (Gewirtz & Edleson, 2004). How children perceive and attribute causes of parental violence can also be a protective factor, particularly if they can avoid pessimism and self-blame (Hughes et al., 2001). The ability to make sense of traumatic experiences is a crucial factor in resilience as it can help children cope with stress and is a foundation for developing intervention programs (Gewirtz & Edleson, 2004; Wolfe et al., 2003). Clearly, individual characteristics are important for resiliency, but to a large

extent the ability of a child to realize the value of such protective factors is linked to family and community supports.

The most important protective resource to enable a child to cope with exposure to violence is a positive relationship between the child and a competent and sensitive adult, most often a parent (Hughes et al., 2001; Levendosky, 2000; Levendosky & Graham-Bermann, 2000). As shown in studies, secure parent-child relationships marked by positive interactions, nurturance, affection, and consistent discipline (Hughes et al., 2001; Margolin, 1998) have been linked with resiliency in children. Most children rely on one or both parents to provide nurturing support in the face of crises and traumatizing situations, and with the support of good parenting, a child's cognitive and social development can progress positively (Levendosky, 2000). But ongoing exposure to violence can impair the parents' abilities to meet their children's needs, and children themselves may be less able to turn to their parents for support and reassurance when one parent is a victim and the other is the perpetrator (Levendosky, 2000; Levendosky, Lynch, & Graham-Bermann, 2000; Osofsky, 2003).

If parents are incapacitated or unavailable to meet their children's needs, a relationship with a significant other or involvement with a community activity or organization may protect children from exposure to violence and aid in their resilience (Gewirtz & Edleson, 2004; Wolfe et al., 2003). Werner (1990) argues that resilient children are skillful at finding alternative parents if their own are unavailable or incapacitated. These alternate caregivers, often extended family members such as aunts, uncles, or grandparents can serve as role models, and play a central role in facilitating the child working through the stress and trauma of witnessing violence by

providing additional adult nurturing and positive models of identification (Gewirtz & Edleson, 2004). Schools and teachers also have an enormous potential for providing emotional support and nurturing to children exposed to violence. At school, children have the opportunity to benefit from the support of peers, which has been shown to be instrumental in reducing anxiety among children exposed to partner abuse (Osofsky, 1999). Having said that, it is important to note that it can be difficult for children who have witnessed parental violence to use these external resources employed by resilient children. For example, social isolation is a common dynamic in violent families and this may impact on the child's ability to access outside supports from extended family. In addition, such children may not be able to rely upon peer support as their social development may have been compromised due to their exposure to parental violence. Further, school may not be a positive environment for these children as many children who are exposed to violence are unable to concentrate and have difficulty adapting to the structured classroom routines, which are in sharp contrast to the disorganization and chaos they experience at home.

In summary, a developmental psychopathology framework, which takes into account the concepts of risk and resilience, is useful for understanding the functioning of children who have experienced violence in their families. Werner and Smith (1982) assert that children's response to violence is determined by the balance between risk factors, stressful life events, and protective factors. As long as this balance between stressful life events and protective factors is favourable, successful adaptation is possible. However, when stressful life events outweigh the protective factors, even the most resilient child can develop problems. This research on resilience points to

the importance of a more systemic approach to understanding child well-being and provides a foundation upon which appropriate action can be taken to reduce the risks and enhance resiliency in children exposed to parental violence.

Summary of Effects of Violence on Children

Witnessing parental violence can be a profoundly traumatizing experience for children, with significant effects on their cognitive, emotional, and behavioural functioning. These children may also experience more subtle effects of witnessing violence, which include distorted and ingrained beliefs about who is responsible for the violence in their home, and may exhibit a lack of knowledge and skills in dealing with violent situations. Children experience these effects directly through exposure to violence perpetrated against their mothers, and also indirectly through parent-child relationships which become distorted and compromised as a result of the violence. While research on the impact of exposure to violence suggests that children are at risk for a variety of short term and long-term consequences, the reality is that many children exposed to parental violence are asymptomatic. This observation has resulted in the realization that the effects of exposure vary with a host of factors, including gender, individual characteristics, and developmental stage. The literature on children's resilience is limited, therefore it is important for future research to provide better understanding of the factors which enhance the resilience and coping of children, since such knowledge can be incorporated into both preventive and therapeutic efforts.

Intervention

Intervention for children exposed to parental violence is a pressing need, because of the potential emotional and behavioural consequences of witnessing violence between adults in the home. In addition, because exposure to violence as a child is the leading risk factor and predictor for males abusing women (Jaffe et al., 1990), interventions designed to ameliorate this risk and prevent violence in this group of children while they are still young would appear to be a high priority in order to prevent future domestic violence (Graham-Bermann, 2001). However, current literature does not address the full range of intervention modalities available for work with children who have been exposed to parental violence. Furthermore, the efficacy of many interventions is largely unknown as there are few thoroughly researched evaluations (Graham-Bermann, 2001; Sudermann, Marshall, & Loosely, 2000). Nonetheless, there is a growing awareness that therapeutic interventions are an important part of the healing process for child witnesses of violence (Jaffe et al., 1990). While many of these children may not need therapy because they are resilient and possess a wide range of coping skills, the majority of children will benefit from the opportunity to share their experiences, identify sources of worry and concern, and learn that they are not alone in their trauma (Graham-Bermann, 1992, 1998).

The need for child therapy may be recognized by professionals, such as when the child's caregiver seeks help after she leaves her abusive partner, in crisis situations because of police or shelter involvement, or when a child discloses witnessing violence at school, in a treatment setting, or during a child welfare investigation (Wolak & Finkelhor, 1998). Alternatively, the behaviour of children may ultimately

draw them and possibly the family into therapy. The primary goal for intervention is to stop the violence in order to establish a foundation of safety within which family members can begin to heal. Subsequent goals for intervention should emerge from a comprehensive assessment of both child and family. While a thorough discussion of procedures for evaluating children and their families is not possible within the context of this review, several points would seem crucial to mention. First, it is essential that helping professionals ensure that the child is safe. If parental violence or child abuse is determined to be an active problem, children may need to be protected, because if they do not feel safe in their home they will not be able to focus on making behavioural and emotional changes (Jaffe et al., 1990; Sudermann & Jaffe, 1998). Examination of the family environment in which the violence has occurred, and the nature and extent of the child's symptoms that may have developed in response to the violence, is also of critical importance and may highlight areas to target as part of the intervention. A wide range of areas should be addressed including emotional problems, behavioural problems, post traumatic stress disorder, school and social adjustment, attitudes and beliefs about violence and gender roles. Once a child's symptoms and concerns have been identified, along with his or her strengths and resources, the therapist can implement an intervention that is appropriate to the child's needs.

The intervention most widely recommended for working with children of abused mothers is the small group format (Graham-Bermann, 2000; Hughes, 1988; Jaffe et al., 1990), although individual therapy is another treatment option. A decision concerning individual or group treatment will be guided by available resources,

preference of the child, and preference of his or her family (Lowenstein, 1999). There is no research that compares the benefits and drawbacks of these modalities, other than the suggestion by some authors, such as Wolak and Finkelhor (1998), that a child who has been exposed to more severe or prolonged violence might require individual treatment as well as or instead of group treatment.

Regardless of the modality selected, work with children inevitably includes work with adults, and a family focus is essential (Peled & Davis, 1995). Close collaboration with children's caregivers is a critical element of any treatment program, not only to empower and support the important adults in a child's life, but also to increase the probability that therapeutic gains will generalize to the real day-to-day world. Parental co-operation may not, however, always be forthcoming or the parent may be unavailable to support the child through treatment (James, 1989; Wolak & Finkelhor, 1998). Absence of parental involvement points to the need for additional co-ordination and intervention on the part of the agencies and professionals involved with the family, such as child welfare, the school system, or relatives.

Group Work as an Intervention

Group work is a tempting intervention for use with children exposed to parental violence as it serves a number of concurrent needs. It is educational in that children learn how to cope with stressors, and social, as children have the opportunity to relate with peers in a context that is enjoyable and familiar. Further, it is cost-effective as one or two therapists can simultaneously intervene with a number of children (Peled & Davis, 1995; Sudermann et al., 2000). As illustrated by Peled and Davis' (1995) work, the importance of a relational context for treatment and resilience

development cannot be overemphasized, supporting the utilization of group treatment. Many children who witness parental violence are instructed to be silent and believe that they are the only ones in that situation, resulting in a devastating form of emotional isolation. The group context is a supportive arena for children to share their experiences and learn that they are not alone in their trauma. Children can also learn helpful coping and problem-solving strategies from group members and leaders. In addition, because the group format is similar to other activities, such as school and community activities that children are familiar with, it may not be as isolating and stigmatizing as other forms of treatment.

There are many approaches to group work, each based on different theories or different therapeutic models (Papell & Rothman, 1980; Fatout, 1996). However, in the area of working with children exposed to parental violence, a generic, psychoeducational group work model has emerged and is widely used in women's shelters and in community counselling contexts (Sudermann & Jaffe, 1998). This model, which is largely based on research by Jaffe et al. (1986), still varies from service to service, however, key characteristics can be described. On average, group sessions incorporate a structured format, are 60-90 minutes in length and run from six to ten weeks (Jaffe et al., 1990; Peled & Davis, 1995). They tend to target children between the ages of six and fifteen, grouping children according to their developmental levels (McAlister Groves, 1999). Each session is structured to accomplish specific goals through educational activities. These goals often include helping child participants define violence and responsibility for violence, identify feelings, improve problem solving skills, strengthen coping and social skills, enhance

self-esteem, develop safety plans, and increase social support networks (Peled & Davis, 1995; Peled & Edleson, 1995). A variety of educational and enjoyable activities can be used to achieve these goals. These activities typically address parental violence through distancing, that is by using stories, films, drawings, puppets, etc. This method is comfortable for most children because it allows them to react openly to the issues without the pressure to discuss their own particular family (Graham-Bermann, 1992). Additionally, a snack is provided, as this contributes to the children receiving nurturance, practising social skills, and having a positive and fun experience in the group (Peled & Davis, 1995).

In addition to achieving goals through structured activities, group interventions are designed to take advantage of the process of relationships that occur for each child throughout the duration of the sessions. Relationships are formed with both the group leaders and others in the group, and both types of relationships are though to be helpful, especially for children undergoing the trauma of parental violence (Graham-Bermann, 1992; Peled & Davis, 1995). In addition to providing information to the children about how to deal with the violence between their parents, the group leaders have the role of providing support and empowerment to the children. Group leaders serve to value each child and to clarify that children are not responsible for the violence between their parents. Ideally, the children will feel more empowered about their reactions to the violence, both in how to appropriately express their own anger and in how their feelings of anger towards their parents are reasonable responses to this violence (Peled & Davis, 1995). With the help of empathic group leaders who have formed a working alliance with the group, new concepts can be considered and

possibly incorporated into the child's repertoire of interpersonal relationships (Graham-Bermann, 1992).

Relationships with peers in the group are equally important in that there can be a special quality of relief and comfort in being with other children who share the "secret" of parental violence in their own families (Peled & Davis, 1995). Group interventions provide the children with an opportunity to build relationships with peers in a safe environment, where they can exchange information and impressions, and feelings about the violence (Sudermann et al., 2000). Connection with other children who have witnessed parental violence may decrease their cognitive distortions, provide them with a sense of interpersonal validation, and build a sense of community (Jaffe et al., 1990). This sharing and validation of a child's worries and concerns can provide an aspect of healing that is not available from other types of intervention. In summary, group work is a common intervention preference for this population of children as it can address the unique aspects of children's traumatic experience of witnessing violence and need for relational connection.

While group work has many benefits, the literature has suggested that group interventions are not appropriate for all children. The most essential characteristic of a potential group member is his/her ability to interact in a social situation (Peled & Davis, 1995). Other characteristics include developmental level, intelligence, ability to communicate, and a strong desire to belong to the group (Peled & Davis, 1995). Following these guidelines, McAlister Groves (1999) suggests that groups are less appropriate for pre-school children, who are typically more impulsive, have short attention spans, and are less likely to use peer relationships to cope with stressful

issues than are older children. She recommends individual therapy with a strong parental component for children of this developmental stage. In addition, groups are generally not suitable for children who may be severely traumatized, because such children have more complex needs. They too, are probably also best served by an individualized approach (McAlister Groves, 1999). Group work may however be a good supplement to individual therapy for these particular children, in that the child can benefit from the opportunity to work on issues surrounding parental violence with other children who have had similar experiences.

Children who have been abused themselves in addition to witnessing parental violence may also need special treatment consideration. Some researchers have speculated that abused children may be reluctant to share openly in a group designed for child witnesses, as they may sense that they are alone in their experiences (Peled & Edleson, 1992). In addition, abused witnesses seem to suffer more detrimental effects than non-abused witnesses (Hughes, 1988). Peled and Edleson (1992) suggest that perhaps separate groups should be formed for abused witnesses, or at least the leaders should ensure that the group is comprised of several children who have been subjected to abuse as well as the witnessing of violence.

Research on the effectiveness of group work with children exposed to parental violence is still in its infancy (Ezell et. al., 2000; Graham-Bermann, 2000, 2001). Nonetheless, there is some evidence that group interventions are helpful and beneficial to this population of children. For example, Wilson, Cameron, Jaffe and Wolfe (1989) evaluated a psychoeducational group for children residing with their mothers in a shelter. These authors reported success in changing children's self-esteem, attitudes

about violence, and personal safety skills. Wagar and Rodway (1995) subsequently transported this group intervention to a community setting and while the group intervention did not change children's knowledge of safety skills or use of social support, it did significantly reduce children's self-blame for parental violence and had significant positive effects on children's attitudes and on their responses to anger.

More recently, Pepler, Catallo, and Moore (2000) evaluated a ten-session, shelter based, peer group program in Canada and reported significant reductions in children's levels of depression and anxiety and an improvement in emotional and hyperactive behaviour. These findings were consistent with Peled and Edleson's (1992) qualitative evaluation of the Domestic Abuse Project (DAP) in Minneapolis. This model of group counselling was reported to have created a safe environment which fostered education about abuse, emotional disclosure, the achievement of new and healthy attitudes and the promotion of protection and safety skills. Interestingly, this study also revealed that while the group process facilitated healing for the children, it also had the potential for creating stress effects on the child and his/her family. For example, while children were able to develop and remember a protection plan for themselves, the concreteness of the plan forced the possibility of future violence into the consciousness of some of the children. Another example involves the group rule of confidentiality. Although the norm of confidentiality contributed to children feeling safe, it was found to have an unintended influence on some parents who found it hard to avoid feeling curious, rejected, and a loss of control when their children chose not to share their group experience with them. In this way, confidentiality put a boundary between the child and his/her mother, and at times

influenced the power balance between them by granting the child the advantage of control over desired information (Peled & Davis, 1995). This study illuminated the importance of involving parents in the intervention process, ideally through parallel groups or minimally through ongoing communication between group leaders and parents, so that they can understand what their children are learning and participate in the process.

Graham-Bermann (1992) evaluated the Kids' Club, a group based intervention for 6-12 year old children and their mothers. Participants in the Kids' Club were recruited from the community and were randomly assigned to one of three groups: child only intervention, child and mother concurrent intervention, and wait list. The child only intervention consisted of ten weekly group sessions focused on children's knowledge, attitudes and beliefs regarding parental violence, as well as their emotional adjustment and social skills. The mother intervention consisted of a ten-week empowerment group, with the goals of improving mothers' parenting skills and enhancing their social and emotional adjustment via discussion of their parenting fears and worries in a supportive atmosphere. Results of the evaluation indicated that children in all three conditions improved with regard to internalizing symptoms, aggression, and conduct problems. However, children in the treatment groups also evidenced reduced self-blame for parental violence, increased coping skills, and greater knowledge about the prevention of parental violence. Notably, the greatest changes occurred in the concurrent child and mother group with regards to knowledge and attitudes about parental violence and reduction of externalizing behaviours,

thereby supporting Peled and Edleson's (1992) recommendation to involve parents in the intervention process.

Many of the studies that have been conducted on child witnesses to date are small scale, lack the use of control groups and largely are inconclusive (Graham-Bermann, 2000, 2001; Hughes, 1982; Peled & Edleson, 1992). In addition, the majority of evaluations have been based on children living in shelters. Shelter samples may bias the outcome as issues facing children who have accessed shelter may differ from those who have not. Consequently, the cited successes of shelter-based interventions may in fact reflect the needs of this specific population and may not be representative of other sub-populations. Furthermore, most of the research exploring the association between group interventions and children's adjustment has relied upon secondary reports of the child's behaviour, such as asking the mother to complete the Child Behavior Checklist (e.g., Jaffe et al., 1986). There are disadvantages to relying upon such secondary sources, in that other factors such as a mother's stress, distortions in her own perceptions, and gender biases may negatively influence her rating of her children's behaviour (Jaffe et al., 1990). Therefore, many of the conclusions drawn so far about the impact of group interventions can be considered as tentative. However, the research to date is encouraging and suggests that group interventions may provide support to children exposed to parental violence.

Individual Therapy

The literature offers little information on individual therapy as a potential intervention with children who have been exposed to parental violence. This may stem from the fact that group work is the most widely recommended intervention for

working with children of abused mothers (Hughes, 1988; Jaffe et al., 1990; Wilson et al., 1989). However, some authors do advocate individual therapy for child witnesses, arguing that in contrast to a group therapy model, individual therapy can offer these children an approach that is more flexible and less time constricted (Jaffe et al., 1990). As a result, the individual therapist is able to view each child's experience as unique and develop specific treatment goals to meet the child's needs. Additionally, because assessment is an ongoing process throughout individual therapy, the treatment plan and its objectives can be changed or modified as needed (James, 1989; Silvern et al., 1995).

There are many different approaches to individual therapy, however when working with children who have been traumatized, most child therapists agree that the use of play is essential in order for children to embrace therapy and process emotional issues (Gil, 1991; James, 1989; Lowenstein, 1999). Therapists advocate for the use of play therapy with children for many reasons. First, play activities help to create a certain degree of distancing of the child from his/her painful experiences, thus allowing him/her to process the traumatic event in a less anxiety-ridden and more gradual manner (Graham-Bermann, 1992). Second, play helps build a positive relationship between the therapist and the child and it also serves to sustain the child's interest and motivation throughout the therapy process (James, 1989; Lowenstein, 2002). Third, children can often communicate their thoughts and feelings more effectively through play than they can through traditional "talk therapy." This is primarily because most children have not yet developed abstract reasoning skills and have limitations around the amount of emotional material they can process verbally.

Play therapy can be either *directive* or *non-directive* in its approach (Gil, 1991; Guzzi DelPo & Frick, 1988). Non-directive play therapy is characterized by the active role of the child as the initiator of spontaneous play and by the participant-observer role of the therapist whose actions are responsive to and guided by the child (Gil, 1991; Guzzi DelPo & Frick, 1988). The child is in charge of the theme, content, and process of the play, and he/she selects the toys, and controls the pace (Guzzi DelPo & Frick 1988). The therapist remains supportive, but non-intrusive, allowing the child to lead and engage in spontaneous play.

Non-directive play therapy has its roots in psychoanalysis. Consistently, play is seen as an activity used by children to work through traumatic life events (Gil, 1991). In the process of non-directive play sessions, children are able to re-experience past traumas and gradually assimilate those experiences in a way that is beneficial to their psychological functioning (Gil, 1991; Guzzi DelPo & Frick, 1988). This re-experiencing gives the child opportunities to deal with and ultimately master difficult experiences. Non-directive therapeutic techniques involve mutual storytelling, unstructured play, and presentation of "specific stimulus materials" (Guzzi DelPo & Frick, 1988, p. 264) for playing out a distressing event. Non-directive play therapy methods, which tend to be long-term in nature, have traditionally been used in work with traumatized children, as many therapists believe that this particular model provides more depth in the therapeutic relationship than directive approaches (Gil, 1991).

Directive play therapy is short-term approach that involves the therapist taking an active role in the play and structuring the session to help the child achieve a number

of goals in a manner similar to that of a group, or according to what he/she believes will be beneficial to the child, based on knowledge of child development and understanding of life events that a child has experienced (Gil, 1991). Although a child may be active in the directed therapeutic play activity, spontaneous input into this type of play is limited by the pre-planned structure of the theme, content, and pace of the prescribed activity (Guzzi DelPo & Frick, 1988). Accordingly, the child's role is that of recipient of information presented in a playful manner by the therapist. However, directive play therapy also encourages the child to participate in interactive activities, which can help the child improve his/her social skills. This modality allows the therapist to set the goals for the current session and for further sessions in the treatment process. By involving the therapist directly in the session, the child can feel less intimidated to perform or express his/her emotions. This way, the therapist normalizes the activity, which therefore encourages the child to engage in the activity. In directive play therapy, therapists use puppetry, colouring books, films, games, and dramatic presentations to provide information, teach skills, and model desired behaviour and attitudes (Guzzi DelPo & Frick, 1988).

Despite an apparent bias towards non-directive therapy both in the literature and in practice, directive play therapy models are becoming increasingly popular (Kaduson & Schaefer, 2000). This is because they are just as effective with respect to desired outcomes, and because long-term, non-directive therapy may not be an option for parents or agencies who have limited time and financial resources (Kaduson & Schaefer, 2000). Furthermore, many authors suggest that because traumatized children are so well defended and anxious, a directive approach may be needed to "elicit

material from the child that is unlikely to emerge spontaneously, and to demonstrate that the issues need not be shameful and can be dealt with directly" (James, 1989, p. 3).

The controversy over directive and non-directive therapy has historically divided professionals, however current literature suggests that the best approach when working with traumatized children, is an integration of directive and non-directive styles (Gil, 1991; James, 1989; Lowenstein, 1999). Therefore, when working with children who have been exposed to violence, a directive play based approach might be used to help children achieve a number of goals in a manner similar to that of the group. In doing so, however, the therapist must recognize that violent families often encompass multiple problems (Gil, 1991), and therefore a non-directive, or flexible therapeutic style, might also be employed in sessions to allow children to focus on the issues that are of primary concern to them.

Regardless of the play technique being used, it is the relationship that develops between the child and the therapist that is considered crucial to the whole process (James, 1989; Lowenstein, 2002). Therefore, at minimum, play therapy should foster a positive client-therapist relationship so that children can experience the notion that intimacy does not always involve threat (Gil, 1991), and to show that "the therapist genuinely cares about him (or her), in spite of knowing all about the traumatic experience in the child's life (James, 1989, p. 49).

Directive play therapy was the primary approach utilized for this practicum, although elements of non-directive therapy were incorporated as well. When putting this modality into practice, three phases are involved (Lowenstein, 1999). In the

beginning phase, the therapist engages the child and develops rapport. In the middle phase, the interaction between child and therapist intensifies and the child works on treatment issues and goals. The ending stage is a time to review the child's progress and prepare for the termination of treatment. Throughout the process, and in each session, intervention activities are appropriately sequenced. This means that beginning engagement activities gradually progress to activities that are more emotionally intense, or that require the child to take greater emotional risk. Ending activities consolidate the skills learned during therapy, encourage the child's independence, and celebrate the child's achievements (Lowenstein, 1999). Activities should be sequenced to move along a continuum of nonthreatening activity to threatening so that the child gradually becomes desensitized to the problem area (Graham-Bermann, 1992; James, 1989). The pacing of the process must therefore be consistent with the child's sense of emotional safety, and of his or her integrative capacity (Lowenstein, 2002). As the therapy process moves into emotionally laden material, the therapist may encounter some resistance from the child, whose initial enthusiasm in treatment may turn to passive or active resistance once sessions provoke anxiety. If this occurs, it may be necessary to change to neutral activities until the child's behaviour is stabilized.

As noted by James (1989), there are several critical aspects of treatment that should be considered throughout the therapy process. First, the child needs to acknowledge and explore his pain while in therapy, in order to resolve his/her traumatic experience. Children who do not accept the reality of their experience, often develop strong defence mechanisms, such as dissociation and repression. Such

defence mechanisms are used to help children to cope with their pain, but eventually they may become maladaptive and impede child development.

Second, it is important for therapists to recognize that trauma resolution does not mean that the child's emotional pain will disappear. Traumatic experiences often resurface for children and take on new meanings for them at various points in time (James, 1989). Therefore, therapy must be made available to children throughout their lives, so that it is responsive to new issues that surface as the child progresses through different developmental stages.

Treatment and intervention strategies should also be developmentally and culturally sensitive, and they should aim to gain and maintain the child's interest and motivation (James, 1989; Lowenstein, 1999, 2002). To this end, playful activities, such as artwork, letter writing, or board games can be incorporated into the therapy sessions. The therapist may wish to create activities for the child, or activities can be chosen from existing therapeutic workbooks. Treatment should also be competency-based, and activities should be chosen according to the child's strengths and abilities (Lowenstein, 2002). For example, with children who have creative writing skills, story and letter writing might be appropriate. Similarly, Aboriginal children might benefit from a culturally based activity such as making a dream catcher.

Another important consideration, stressed by James (1989) is that the child should not be treated in isolation from his or her family and community. A systemic approach to treatment helps ensure that all of the child's needs are met appropriately and sensitively. For example, a treatment goal for a child exposed to violence might include strengthening or improving the child's attachment to a parent or caregiver, and

this requires the adult's active participation in the therapy process. How much and to what extent a parent can be involved is often a complex clinical decision. Such decisions should be based on the therapist's assessment of many factors, such as whether the parents will need help in modifying their interactions with the child, and whether the child will need assistance in implementing a treatment plan outside of therapy (James, 1989). In some cases, if the parents are too intrusive, or overwhelmed with their own needs, it would be best to involve them no more than minimally (James, 1989).

Finally, therapists must recognize that traumatized children often harbour powerful beliefs that they are helpless, bad, and responsible (James, 1989). The messages the child receives from therapy must therefore challenge the intensity of these negative beliefs in order to be heard, felt, and trusted by the child. It is fun that keeps children emotionally receptive; therefore, the use of play is essential to convey intense positive messages to the child. When the therapist uses a playful approach, the child receives the message that he/she is fun to be with. Incorporating good times in the treatment process also teaches the child that it is acceptable to have fun and that despite the pain, life can move forward (James, 1989).

According to directive play therapist Beverly James (1989), clinical work with traumatized children should focus on four major areas: communication, sorting out, education, and perspective. James (1989) cautions that these areas are not as neatly separated in practice as they are in theory, and overlapping of categories should be expected.

In accordance with these guidelines, the first step in the therapeutic process involves helping children to *communicate* their complex and conflicting thoughts and feelings regarding their traumatic experience. Some children may feel comfortable in therapy and have the capacity to express their feelings and experiences verbally through direct discussion, however the majority of traumatized children do not have the language skills or understanding of complex feelings to be able to communicate their feelings accurately. As such, children should first be taught to identify and distinguish the various feelings common to all children. They can then be helped to develop methods for communicating their own emotions to the therapist. This is done with an understanding that emotions related to the traumatizing event should not be explored until children have developed some skills in communicating emotions, and feel confident that it is safe to do so (James, 1989; Lowenstein, 2002). Once children learn how to identify and communicate various emotions, they can then be taught how to express simultaneous, conflicting feelings, with the understanding that it is normal to have many different feelings. This process typically involves interactions during which the therapist establishes, through a combination of art, music, play, and direct discussion, a common language through which children can express themselves. Children are thereby given the message, both directly and indirectly, that they will not get into trouble for expressing feelings, that the therapist will not be overwhelmed by their emotions, and that the therapist can empathize, control and guide them. *Feelings Tic Tac Toe, Go Fish,* and *Candyland,* are all activities that can used with children to help them express their feelings (Lowenstein, 1999, 2001).

Once an atmosphere of safety and trust has been developed, and the child has learned important communication tools, the next phase of treatment, *sorting out,* can begin. This phase is a process of exploration, whereby the therapist and child sort out the child's understanding of the traumatizing event; the meaning of the event to the child; the child's feelings and behaviours before, during and after the traumatic experience; and the child's worries related to self, siblings, and family. In a supportive, respectful manner, the therapist facilitates the child being able to acknowledge and accept his or her feelings and behaviours that are related to the traumatizing event. By comprehending the events and his or her coping responses, the child's experiences are validated and normalized. Additionally, bringing the violence into the open sets a foundation upon which issues such as self-blame, feelings of powerlessness and other types of misinformation can be clarified and addressed in subsequent sessions.

The third phase of the therapeutic process involves *education*, whereby children learn to understand the specific elements of the traumatizing experience and the roles of the various persons involved. To achieve this the therapist can incorporate various play media to help correct cognitive distortions about gender roles, the use of violence to solve problems, and/or beliefs about responsibility for the abuse in their family (Silvern et al., 1995). Puppetry, for example, is an excellent medium for addressing issues of blame and responsibility with children who have been exposed to parental violence. The therapist might use puppets to portray a family situation in which there is domestic violence. The therapist can then debrief with the child by

clarifying the roles and responsibilities of each puppet family member, and the feelings that each might have experienced.

Another part of the education process involves helping children learn to control their own disruptive behaviours. More specifically, children learn to identify the factors that trigger unwanted behaviour, skills that will allow them to gain control of their behaviour, and alternative ways to express themselves and to have their needs met (James, 1989). Children also learn that they are responsible for their actions, that adults can help to control and protect them, and that it is acceptable to ask for help. A good example of this approach is helping children learn more appropriate ways of expressing their anger. A child who has been exposed to violence may feel anger but may not have the ability to put these feelings into words. As such, the child may express this anger through overt, behavioural displays such as physical aggression towards siblings or peers. This behaviour not only hurts others and invites rejection, but also exacerbates the child's negative self-esteem and feelings of isolation (James, 1989). Helping the child express anger in more appropriate ways, such as through words, may lead to better emotional and behavioural self-regulation. Similarly, helping the child express feelings of sadness or hopelessness pertinent to their victimization may prevent the formation of such symptoms such as depression.

A final part of the therapy process, referred to as *perspective*, involves the integration and acceptance of the traumatizing events in the history of the child (James, 1989). Through the child-therapist relationship, and through discussions and activities, the child develops a sense of self in which it is acknowledged that he/she is more than his/her experiences. The traumatic event(s) is therefore accepted as

something that has happened to them, without the need for exaggeration or minimization of its impact (James, 1989). Ideally, traumatized children will reach the point where they can say, for example, "Yes, that happened to me. That's how I felt and how I behaved when it happened. This is how I understand it all now. I won't really forget it happened, but I don't always have to think about it either" (James, 1989, p. 49).

Overall, individual play therapy seems compatible with the needs of child witnesses for a therapy that is nurturing, non-threatening, and adaptable for use with various emotional and behavioural problems. Unfortunately, there is little empirical research on individual play therapy as it relates specifically to children who have been exposed to parental violence. However, Silvern and her colleagues (1995) provide a case study of the effectiveness of individual therapy with a child witness of violence and suggest that there is an urgent need to develop and evaluate treatments for children of abused women. They strongly advocate for the inclusion of individual therapy among treatment options for this population.

Family Based Interventions

Both research and clinical findings consistently point to the strong relationship between the adjustment of child witnesses to violence and the adjustment of their abused mothers (Graham-Bermann & Hughes, 2003; Levendosky & Graham-Bermann, 1998). In general, the more depressed, anxious, isolated and traumatized an abused woman is, the greater the level of her children's emotional and behavioural problems (Levendosky & Graham-Bermann, 2000). This finding means that counselling and support for the abused mother can offer an indirect benefit to her

children. A few models have been developed to address this need. While there are no formal evaluations of these programs, they appear promising with respect to supporting these women, strengthening their relationships with their children, and preventing future emotional and behavioural problems in their children.

Concurrent Groups for Mothers

An approach which involves mothers in the child's therapy through their participation in a concurrent or parallel group, demonstrates to children that their mothers are critically important in their lives, and replaces the message of devaluation of mother to one where the mother's role is valued in caring for her children. The parallel group model is beneficial in that mothers are given an opportunity to support each other by sharing child-related needs and concerns. In addition, the group provides a safe context for keeping mothers informed about the content of the children's groups and for discussing questions and concerns they may have regarding their child's group experience (Peled & Davis, 1995). It is important to inform mothers about the content of children's group sessions for several reasons. First, sharing this information with the mothers prevents it from becoming a secret between child and parent, thus permitting the children to share thoughts and feelings about the group experience with their parents. This, in turn, may lessen the child's feelings of shame and isolation. Second, prior knowledge of the group content can help parents anticipate, accept, and be prepared for their child's emotional and behavioural reaction to the group (Peled & Davis, 1995). Third, parents can reinforce messages and behaviour learned in the children's group, thus assisting in integrating group content into their child's daily life (Peled & Davis, 1995).

Parallel groups for mothers are typically psycho-educational in nature, and run simultaneously with the children's group. Peled and Davis (1995) have described one such model where group topics for mothers include the effects of witnessing violence on children, the effects of early life experiences on parenting, child development, parental and children's rights, discipline versus punishment, self-esteem in children, communication and changing families. According to the authors these topics are not exhaustive, but do provide a foundation for healthy and effective parenting in families that have experienced violence. Involvement in a parallel group will ideally empower women as mothers, and assist them in meeting their children's needs. However, it is important that these women first tend to their own personal issues such as securing safety, or mourning the end of their relationship (Bilinkoff, 1995). It is only after women have tended to their victimization needs, that they will be in a position to provide support to their children and maintain a focus on their needs (Peled & Davis, 1995).

Multi-Family Groups

The multi-family group treatment approach offers another unique way to employ parents in the intervention process and enhance parent-child attachments. This model has emerged from a feminist-informed, family systems perspective and is beneficial as it involves peer and family support for healing in the post-crisis and post-violence stage for families who encountered violence in the past (Rabenstein & Lehmann, 2000). More specifically, multi-family group work involves parents, children, and at least one facilitator. The group highlights and builds upon the interaction between all participants across family and age boundaries. Children have

their own parent, other children, other mothers, as well as group leaders to validate their experiences, challenge misperceptions and share ideas with. Rabenstein and Lehmann (2000) have described one model of multi-family group work in which the group objectives include restructuring the family through enhancing the mother's parenting capabilities, talking about abuse in safe ways, debriefing traumatic stories, taking a family-wide stance against abusive behaviour, searching for non-violent alternatives in the extended family and co-creating a non-violent future. These authors emphasize that the family must be in a certain state of readiness prior to engaging in this work. In particular, mothers must be at a point where they recognize the effects of violence on their children and are ready to support and assist their child. This means that crises involving basic needs or safety should be resolved. While there are limited empirical evaluations of family group models, the intervention provides a promising opportunity to address issues of critical importance to the well-being of the child in the family context.

Theraplay

Theraplay is an intervention that aims to rebuild broken bonds and damaged attachments between mother and child. While Theraplay is not a model specifically designed for families who have been exposed to parental violence, it has been applied to children of all ages who are experiencing social, emotional and behavioural difficulties, and it has been found particularly helpful with children who have attachment and trust issues (Munns, 2001). A therapy that focuses on strengthening the parent-child relationship seems particularly appropriate for mothers and children that have experienced violence in light of the unhealthy relationships and imbalance of

power that characterizes violent families. The relational core of Theraplay could potentially begin a new pattern of reciprocal relationships within the family.

Theraplay is a short-term, structured, playful, individual treatment approach that was first developed by Ann Jernberg (1967) for use in Head Start programs. Theraplay uses the type of play activities that characterize the healthy parent-child relationship. There is little discussion and instead the focus is on pleasurable activities that will enable the child to experience the relationship with the adult. In Theraplay, the priority is on personal interaction (Jernberg, 1979), and while there may be a few props, there is minimal use of toys (Jernberg, 1979). Also, as is consistent with a healthy parent-child relationship, it is the adult, not the child, who is "in charge." (Jernberg, 1979). Thus, Theraplay is quite different from traditional child therapy where the child is invited to take the lead in expressing himself verbally, through play, art, or other means. Instead, Theraplay emphasizes the current relationship and offers a level of intimacy not evidenced in other prevailing forms of child therapy.

All children have basic requirements for healthy development within the parent-child relationship. Theraplay conceptualizes these requirements under the terms *Nurture, Stimulation*, *Structure*, and *Challenge.* Theraplay sessions involve a focus on one or more of these areas, depending on the specific needs of each child. The therapist carefully evaluates each child in interaction with his/her mother to develop a unique treatment plan. Activities are then specifically chosen to provide intervention in one of the four major areas. These activities are fun, spontaneous, and should encourage body contact, whether it is playful, competitive, soothing or nurturing. For example, in a Theraplay session, the therapist may discover a child's

muscle and demonstrate that the child is strong enough to push the therapist over; find a freckle right under a sparkling blue eye; rub lotion on the child's soft, tiny hands, or powder two little feet (Rubin & Tregay, 1989). Whatever the activity, the emphasis in always on engaging the child, and surprising him/her with something that is fun. Intervening with the child in this manner provides experiences that meet the child's needs in the four Theraplay areas, guiding him/her in learning to develop healthy relationships with others.

Theraplay treatment acknowledges that parents are the most important people in their children's lives by including them in the process. Initially parents watch the interactions between the therapist and child through a one-way mirror and then they replicate the same interactions with their children under the supervision of the therapist. Parents are also empowered to extend the therapy process with their child into the home environment.

Theraplay techniques can also be utilized in a group context (Munns, 2001; Rubin & Tregay, 1989) and adapted for work with specific populations of children (Rubin & Tregay, 1989). Groups for children traditionally rely on verbal discussion and peer influence to affect growth and change, but Theraplay groups are targeted for children who have difficulties sharing with others and relating to peers (Jernberg, 1979). Accordingly, Group Theraplay is a seemingly appropriate intervention for children who have been exposed to parental violence. The goals of group Theraplay are consistent with individual Theraplay with respect to enhancing children's self-esteem and increasing trust in others through concrete, personal, positive experiences (Jernberg, 1979). Group Theraplay creates a sense of connectedness in the child

through attention, recognition, appreciation, and nurturing (Jernberg, 1979; Rubin & Tregay, 1989). The children deal with personal issues and feelings that are demonstrated via their behaviours, develop greater awareness and understanding of themselves and others, learn to socialize in a positive manner with others and support one another, and learn to advocate for themselves (Jernberg, 1979; Rubin & Tregay, 1989).

Group Theraplay is proactive in the sense that it is not reactive to misbehaviour but meets the needs of the child at his/her developmental level, is experience-oriented rather than discussion-oriented, is highly nurturing, and adult directed which assists the child in recognizing that he/she is safe and secure and can trust others (Rubin & Tregay, 1989). In Group Theraplay three basic rules are established. The first rule is *No Hurts*, which allows for nurturing and disallows pain or anxiety. The second, it *Stick Together*, which indicates inclusion for all, caring for one another, and involvement. The third and final rule is *Have Fun*, which is exciting, positive, and allows for the development of relationships. Each session begins with an introduction and greeting, followed by an inventory of personal body parts and traits, and then active games interspersed with quiet activities involving the four dimensions mentioned previously. Lastly, a closing ritual, such as a song, symbolizes the end of session. Consistent with individual Theraplay, few material objects are used so that the focus is on person-to person interaction.

In summary, the Theraplay model, whether carried out in a group or an individual format, is a promising intervention for bolstering self-esteem and enhancing attachments between children and their mothers who have experienced violence. The

model can be carried out in a pure form, or the techniques can be used to compliment other models of intervention, as they were in this practicum. Unfortunately, no empirical evaluations have been conducted on the model and its effectiveness to date.

Summary of Intervention Modalities

Witnessing family violence can attack the very core of a child's sense of self, relationship security and developmental foundation and thus clinical intervention for this population is an important need. Individualized assessment of children is highly recommended in the literature to determine the level of trauma experienced, as well as the need for direct or indirect intervention to ensure child safety. Many children require intensive short or long-term individual therapy, while the needs of others may be answered through small groups in which children can break the silence surrounding family violence. Other children's coping may be better enhanced by increasing parental support. Still others may have sufficient external and external supports in place to cope without professional intervention. Regardless of the approach, it is essential that the focus be on the children's emotional reactions to the violence in their families. Jaffe et al. (1990) note that children "are almost universal in their need to be listened to, believed, and supported. They usually are not looking for solutions but an opportunity to share their fears about their mother and perhaps all members of the family" (p. 83). In this sense, both individual and group modalities are able to address the unique aspects of children's traumatic experience of witnessing abuse and need for relational connection.

It is with this information in mind that group and individual approaches were chosen for this practicum. Both intervention modalities offer a structured format and

draw upon the techniques of Theraplay and other play based therapy models. Additionally, because the involvement of the non-offending parent can aid in the child's healing, family work was incorporated, as part of the total intervention plan.

CHAPTER THREE-DESCRIPTION OF THE PRACTICUM

Setting

This practicum took place at Elizabeth Hill Counselling Centre (EHCC). The EHCC is located in Winnipeg's inner city and is a training centre for undergraduate, graduate, and doctoral students in the faculties of social work and psychology at the University of Manitoba. It is the mission of the EHCC to provide free counselling to men, women, children, and families, in a manner that is sensitive to cultural, economic, gender and sexual preferences, as well as to personal and social difficulties. Services provided include individual, family, and group therapy, as well as specific therapies such as play therapy and theraplay for children. Clients are voluntary and are self-referred or referred through community agencies.

Supervision and Committee Members

Committee members included Dr. Diane Hiebert-Murphy, a professor in the Faculty of Social Work at the University of Manitoba, Linda Perry, a therapist and program manager at the Elizabeth Hill Counselling Centre, and Valerie Barnby, quality assurance co-ordinator of Winnipeg Child and Family Services and sessional instructor with the Faculty of Social Work at the University of Manitoba.

The supervision was divided between the three committee members, with each individual responsible for a different function and area of supervision. Dr. Diane Hiebert-Murphy, as my primary advisor, assisted in the overall planning and structure of the practicum. Clinical supervision was provided by Linda Perry in the form of weekly meetings, and Valerie Barnby offered consultation on the intervention process

and on the evaluation components of the program. All three committee members reviewed written reports and participated in committee meetings as required.

The Intervention Process

The practicum was set up in two distinct phases. The first phase was a group intervention for children exposed to parental violence. This group was part of an existing parent-child treatment program for women and their children who have been impacted by domestic violence. The twelve- week program involved a group for mothers, a concurrent group for children, and a multi-family mother-child group. In each session the mothers and children participated in their own separate groups, and then joined together in an atmosphere of fun and play, where the experience of family violence was debriefed and issues related to the impact of violence, safety, breaking the secret, and social support were addressed. Unique features of this program included the use of Theraplay activities, as well as a puppet play about family violence. In each session, the mothers and children ate a snack and then played structured activities together. Afterwards, various family violence concepts were introduced through a little boy puppet, named Max. Themes included confusion about the violence, breaking the secret, stopping the violence, feeling afraid, feeling angry, healthy coping strategies, and living without violence. The focus of this practicum was on the children's group, although the mother's group and the multi-family group were crucial components of the overall therapy process for the children.

The second phase of the practicum involved working individually with two children who had been exposed to parental violence. In addition to their exposure to violence, these children were also struggling with other issues. More specifically, one

of the children was immersed in a custody battle and the other child was coping with parental abandonment and drug abuse. An integration of directive and non-directive styles were employed in therapy with these children, however directive play-based activities were heavily relied upon to address many of the same themes outlined for the group intervention and the other concerns the children faced. In accordance with each child's developmental level, personality, and presenting issues, various media such as art materials, books, puppets and role-playing were used to engage them and facilitate discussions. Ultimately, an integration of these materials was used to help the children develop a vocabulary to talk about their feelings and the violence they witnessed, to correct cognitive distortions around issues of blame and responsibility, to create safety plans, enhance coping skills, and practice non-violent conflict resolution techniques. On-going contact with the children's primary caregiver was an integral part of the process. This was carried out through conversations over the telephone or in person contact prior to or after the individual therapy session with the child.

Personnel

Four therapists in total facilitated the group program. A social work student and myself facilitated the children's group. Another graduate student in the Faculty of Social Work and an undergraduate student facilitated the mother's group. Although all the therapists participated in the joint parent-child multi-family group, the graduate student facilitating the mother's group was responsible for the planning and facilitation of each session. Throughout the group intervention, we worked together as a team with a clinical supervisor, planning the overall objectives for each session and

discussing our own impressions with each other after each group meeting in regards to group themes and dynamics, and each of our roles during the sessions.

Selection of Clients

The target population of the group portion of this practicum was seven to ten year old children who had witnessed violence between two primary caregivers. Client referral for individual therapy was expanded to include children between the ages of five and twelve years of age. Requests for referrals were made through referring agents such as Child and Family Services, the Child Guidance Clinic, Probation Services, Ma Mawi Wi Chi Itata Centre, Evolve, Native Women's Transition Centre, the Family Centre, and New Directions for Children Youth and Families. A poster outlining the group and individual formats and criteria, along with an explanation of the purpose of intervening with this population of children as part of the requirement for a Master's of Social Work Practicum, was sent to all of these agencies. In addition, an agency wide e-mail was distributed throughout Winnipeg Child and Family Services, and follow-up phone calls were made to staff of various agencies to verbally discuss the practicum and process of referral.

Eligibility Criteria

Children selected for either an individual or group intervention may or may not have been previously involved in counselling and may or may not have been living with the caregiver(s) who had been involved in the violence. However, as safety was the primary concern, it was necessary for the child to be living in a safe, stable, non-violent environment. In addition, it was preferable for families to be beyond the immediate crisis of the violence, and ready to begin to process its impact.

Furthermore, it was important that the caregiver was supportive of the child's participation in the intervention and willing to be involved in the child's treatment.

Children also needed to be in a certain state of readiness prior to engaging in intervention. It was important for them to be developmentally capable of verbal disclosure and cognitive processing, and that they were not experiencing any major emotional or behavioural symptoms relating to trauma (e.g., suicidal ideation, extreme aggression or withdrawal, self-mutilation etc.). In addition, children who were known to have experienced sexual abuse were not be included in the practicum given the likelihood that they would require an intervention focused principally upon the abuse rather than domestic violence-related issues. However, because the prevalence of woman abuse in a family often overlaps with child abuse (Hughes et al., 1989), children who had experienced direct physical abuse were not excluded from the practicum.

The Assessment Process

The assessment process followed a similar format for each family and for each phase of the intervention. Once identified from the wait list, parents were contacted via telephone and an initial screening and assessment interview was scheduled. The aim of the assessment was to determine whether the child was appropriate for individual or group therapy, was living in a safe environment, and whether the child had been a victim of child abuse. In addition, information was collected about the nature of the violence witnessed by the child, his/her behaviour, and relationships. The initial assessment meeting also served to orientate the family to the EHCC, obtain

the necessary written consent forms, fill out evaluation measures, and assist the child and family to understand the nature and goals of the intervention.

The assessment process consisted of individual interviews with the parent and child and an interview with the parent in the presence of the child. With this approach, the parent served as a model for the child, thus giving the child permission to talk about the violence, in addition to helping the child prepare for his or her own interview. The child interview focused on determining the child's level of functioning, whether he/she was able and willing to separate from his/her parent, the child's willingness to acknowledge the violence that s/he witnessed, and his/her interest and motivation for participating in the group and/or individual intervention.

Duration

The practicum began in September 2002 and concluded in June 2003, for a period of approximately ten months. The group intervention ran for twelve weeks starting in September and the individual therapy component commenced in January 2003 for a five-month period.

Overview of Group Intervention

The response to our request for group membership was limited, therefore families were chosen who fit the eligibility criteria the closest. The end result was a group comprised of four children between the ages of six and eleven years. The group was of a structured, directive format, using a pre-existing group outline, and adapted to meet the unique needs of the children in the group. A variety of techniques such as arts and crafts, videotapes, role-playing, group discussion, and processing of group dynamics were used to address weekly themes. These themes focused on content

commonly covered in groups for children exposed to violence including establishing trust and a feeling of safety, the expression of feelings, defining violence and responsibility for violence, improving communication, problem solving and cognitive coping skills, increasing self-esteem, developing social support networks and safety plans. Each group session was held once a week with sessions lasting one hour in duration. The structure of the sessions included a check in, snack, theme-based discussion or activity, fun and games, debriefing and check-out.

Following is a summary of weekly themes for the children's group:

Week 1	Getting to know each other
Week 2	Different kinds of abuse
Week 3	Feelings
Week 4	Different kinds of hurting
Week 5	Fighting in families
Week 6	Fighting in families should never be kept a secret
Week 7	Mixed up feelings
Week 8	Coping with feeling afraid
Week 9	Angry feelings
Week 10	Coping with bad feelings
Week 11	Safety planning
Week 12	Saying Goodbye

Overall the objectives for the group intervention were to provide a safe, fun, and supportive environment for the children to break the secret of family violence, to process their experience of witnessing violence, to meet and gain support from other children who have shared similar experiences, and to strengthen their self-esteem. In this sense, the group was educational and therapeutic, and also provided a social setting for the children to make new friends, play, and eat snacks (See Appendix A for a detailed outline of group sessions).

Overview of Individual Therapy

Individual work with two children followed a format similar to the group intervention. In particular, sessions lasted an hour and involved a snack, check-in, an engagement game, a theme based discussion and/or activity, followed by play time and a brief check-out. Different goals were contracted for each child, given their unique experiences, behaviours, symptoms, and preferences. However, the primary focus of the individual work with both children was to help them express their emotions about the violence they witnessed in a safe environment. The process involved helping the children to transform their initial feelings of apprehension and resistance into an enjoyable and positive experience. To this end, structured play based activities were used to provide the children with immediate gratification, to reduce their anxiety, and to provide balance for the discussions related to the violence they witnessed. The establishment of rules offered the play therapy context clarity and predictability, which are basic components of a safe environment.

Parental involvement was also a critical component of the child's therapy and where possible, time was spent with the child's caregiver either before or after the session. Sessions with the parent were important for many reasons: (a) to provide the parent with coping skills for dealing with their child, (b) to attempt to produce an attitude of change on the part of the parent toward the child, (c) to provide a positive, supportive environment in which the parent can share challenges that they are having with their child, and (d) to provide information to the parent on the impact of violence on children-with a focus on their needs. Employing the parent as a partner in the child's therapy increased the likelihood that the gains the child made in therapy would

be generalized into his/her day-to-day life. In addition, regular meetings with the child's parent provided an opportunity for her to discuss any personal issues that may have been impacting on the care of herself and/or her child.

Evaluation

The essence of successful practice is in the ability to demonstrate that the intervention has been effective. Evaluation must therefore be considered an essential part of social work practice. The most productive way of assessing the efficacy of the intervention is through the use of standardized, objective methods of research (Bloom & Fisher, 1982). In this practicum, standardized measures were implemented at the beginning of the group and individual intervention, then again at the point of termination. 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:

Child Behaviour Problems/Child Behavior Checklist (CBCL)

Children who have been exposed to domestic violence are at risk for a wide range of both internalizing and externalizing behaviour problems which vary by developmental stage (Pepler et al., 2000). Externalizing problems refer to behaviours that children act out, such as temper tantrums, impulsivity, hyperactivity, or aggression. Internalizing problems are those which reflect the stresses that children endure such as somatic complaints, sleep disturbances, anxiety, depression, or social withdrawal. The group and individual interventions in this practicum were designed to address the behavioural issues of child witnesses by allowing them the experience of a non-violent environment and through the learning of problem solving and social

skills. In addition, the children were offered support and empathy throughout all phases of the intervention. Therefore, the child's behavioural problems, both external and internal were expected to change in positive ways as a result of the interventions. Administration of the Child Behavior Checklist for ages 6-18 (CBCL) (Achenbach, 1991) aided in determining whether the group and individual interventions had any impact on the behavioural problems displayed by the children. The CBCL is a very suitable measure to use with this population of children and was chosen for this practicum because it incorporates the use of both externalizing and internalizing disorder scales. The CBCL was also chosen because of its strong psychometric properties and because it has been used in many studies measuring the behavioural problems of children exposed to parental violence.

For the group and individual interventions, the caregivers for the children completed Achenbach's 120-item Child Behavior Checklist (Achenbach, 1991) for their child. This questionnaire was developed as a standardized measure of behaviour relevant to the study and treatment of child and adolescent adjustment. It provides a rating of a child's behaviour problems and social competencies, according to the parent. The instrument requires at least a fifth grade reading level to be completed; however, it can be read aloud to parents who cannot read at this level. Administration takes approximately thirty to forty minutes.

The CBCL has been used on both clinical and non-clinical populations. The Social Competence Scale asks parents to list various activities in which their child participates, and to rate their time spent and ability in these activities. Scores are given in the three areas: Activities, Social, and School. On these scales, lower scores

are clinically significant, indicating a lack of social competencies. The clinical cut-off scores suggested are T-scores of less than 35. This study uses the social competence score as one indicator of child mental health.

On the Behavior Problem section, parents are provided with a list of 118 behaviour problems on which to rate not true, somewhat true, or very true for their child. Results provide standard scores by age groups (4 to 5, 6 to 11, and 12 to 16 years old) and sex on 8 to 9 different behavioural categories. These syndromes are divided into two broad-band groupings of internalizing (e.g., depression) and externalizing behaviour (e.g., aggression). On each of the behaviour scales, higher scores are clinically significant, indicating the presence of behaviour problems. The clinical cut-off scores suggested are T-scores of greater than 63. This study uses the internalizing behaviour problems and externalizing behaviour problems scores as two indicators of child mental health.

Intraclass reliability coefficients for individual items have been reported to be in the 0.90's (Achenbach, 1991). In addition, the median Pearson correlation for a one week test-retest reliability coefficient was 0.89 for total problem scores. Test-retest reliability for psychiatric inpatients over three months was 0.74. Six month test-retest with outpatients was 0.60. When comparing reports given by mothers and fathers on the same child, the median Pearson correlation coefficient was 0.66.

The authors have demonstrated validity of the CBCL by using referral for mental health services as the criterion. They found significant differences between demographically-matched referred and non-referred children on all profile scores for each age and sex grouping. They also explained that 116 of the 118 behaviour

problem items and all 20 of the social competence items were significantly associated with clinical status, thereby giving the measure content validity.

Several comparisons with other behaviour checklists have been made in order to demonstrate construct validity (Achenbach, 1991). Correlation coefficients comparing the total problem scores of the CBCL with the Conner's Parental Questionnaire range from 0.77 to 0.91. When using the Quay-Peterson Revised Behaviour Problem Checklist, these correlation coefficients range from 0.71 to 0.92. Achenbach (1991) reports that these correlations are as good as those found between most intelligence tests.

Although studies have consistently verified the utility of the CBCL, measures which rely upon the perspective of one caregiver have been criticized for the potential for bias (Porter & O'Leary, 1980). Consequently, it is recommended that evaluations rely upon the use of multiple data sources, including but not limited to, the child and parent (Graham-Bermann & Hughes, 2003). As such, qualitative interviews were conducted with the child and his/her parent to supplement the findings from the CBCL.

Children's Self-Esteem/Piers-Harris Children's Self-Concept Scale (PHCSCS)

Children who have been exposed to parental violence often suffer from low self-esteem (Edleson, 1999). They tend to feel disempowered and different from other children (Peled & Davis, 1995). Self-esteem has also been found to be linked with behaviour problems in general, suggesting that positive changes in a child's self-esteem might influence positive changes in the child's behaviour (Peled & Davis, 1995). As a result, the group and individual interventions in this practicum were both

designed to empower children and strengthen their self-esteem. For example, supportive and validating interaction occurred between the child and therapist throughout all phases of the intervention. The children were also provided with a fun, positive experience with a view that that it would translate into a positive experience of themselves, and of their capacities to be respected and cared for. Administration of the Piers-Harris Children's Self-Concept Scale (PHCSCS) (Piers, 1984) was used in this practicum to measure the children's self-esteem pre-and post-intervention. The PHCSCS was selected for use because it targets self-esteem and this is an important construct for child witnesses to violence. In addition, The PHCSCS has been used in many studies and this speaks to its effectiveness in terms of reliability and validity.

The PHCSCS scale is an 80 item self-report measure designed to assess how children feel about themselves. Children respond "yes", or "no" to declarative sentences. The scale provides six cluster scales: Behaviour, Intellectual and School Status, Physical Appearance and Attributes, Anxiety, Popularity, and Happiness and Satisfaction. The scale is designed so that high scores on the total or subscale scores reflect high self-esteem.

Piers (1984) reported making the effort to build content validity into the scale when it was originally developed by researching the qualities that children either liked or disliked about themselves. The authors then emphasized the categories which were generally believed to reflect a children's self-concept such as personality, character, inner resources, and emotional tendencies.

The Piers-Harris Children's Self-Concept Scale was standardized on 1183 children in grades 4 through 12 in a small American town (Jeske, 1985). The scale

appears to be a highly reliable instrument for measuring the self-concept of children 8-18 years of age. Studies of test-retest reliability of the instrument have resulted in coefficients ranging from .42 to .96, with a median correlation figure of .73, suggesting that the test demonstrates a reasonable degree of stability. These fairly solid correlations also suggest that children's self-attitudes are fairly stable by the age of eight (Piers, 1984). The alpha coefficients on a number of normative samples ranges from .88 to .93, indicating that the instrument has a high degree of internal consistency.

Studies exploring the concurrent validity of the Piers-Harris scale have reported a range of results. Piers (1984) stated that this range may be due, in large part, to the influence of age. For instance, scales which are designed to measure self-concept in younger children 5-8 year olds have not correlated highly with the Piers-Harris, which was designed for children 8-18 years old. However, the Coopersmith Self-Esteem Inventory (cited in Piers, 1984), which is similar to the Piers-Harris in format and age range, did correlate highly with the Piers-Harris (.85). Piers (1984) states, "significant correlations between measures intended to assess similar constructs provide evidence of convergent validity" (p. 67).

Finally, the factorial validity of the Piers-Harris scale has been investigated in a number of studies, the results of which are somewhat mixed. While several studies replicated many of the factors identified in the original factor analysis carried out by Piers in 1963 (Piers, 1984), others "have identified additional factors or failed to replicate all six original factors" (p. 66). In general, however, this scale is considered to be "psychometrically sound" (Jeske, 1985). According to this reviewer, "the Piers-

Harris appears to be the best children's self-concept measure currently available. It is highly recommended for use as a classroom screening devise, as an aid to clinical assessment, and as a research tool" (Jeske, 1985, p. 961).

Client Satisfaction Questionnaire/Post Intervention Interviews

The final method used to evaluate the interventions was a client satisfaction questionnaire (See Appendix B & C) and an unstructured qualitative post-intervention interview. These interviews occurred approximately two weeks after the termination of the group and individual therapy and took place in the context of the child's home environment or community. For example, for most of the interviews I picked the children up at their home and took them for a snack. This presented an opportunity to conduct the interview, fill out the questionnaires, and to have a personal termination with the child. I also interviewed the child's mother at this time to assess her satisfaction with the intervention for her child.

Paperwork/Recording

The Elizabeth Hill Counselling Centre has specific recording requirements, which include consent forms/permission for observation forms, demographic information, intake reports, contact sheets, and termination summary reports. For my own purposes, I kept weekly notes pertaining to the group process and the individual work with the children as well as notes taken from weekly supervision sessions.

CHAPTER FOUR-THE GROUP EXPERIENCE AND ANALYSIS

Group Composition

In planning a group, one needs to decide on the membership criteria. The goal is to plan a group in which individual members will feel comfortable, and in which the group as a whole can develop cohesion (Nisivoccia & Lynn, 1999). Accordingly, each child that participated in the group intervention was first screened and then assessed to determine his/her appropriateness for the group, as per the criteria outlined in the previous chapter. Unfortunately, the response to our request for group membership was limited. Therefore, we selected children who fit our criteria the closest. The literature argues that simply grouping together available children can reduce the effectiveness of the therapeutic process and progress for individual children (Nisivoccia & Lynn, 1999). This issue was recognized, however we decided that the risk of not providing service to certain children outweighed the risks of including them in the group.

Referrals for the group intervention came from a variety of sources. The majority of referrals were from Child and Family Services. Other referral sources included the school system, and self-referrals. While many children were screened for the program, four were selected to participate. The children were of mixed gender ranging in age between six and eleven years. The children were also from a variety of ethnic backgrounds and socio-economic groups, although it was established that all of the families were struggling financially. Each child had witnessed violence perpetrated by their biological father towards their mother. One of the children had been placed in foster care due to the violence, and three of the children had been in

shelters. None of the children had been or were currently involved with other therapeutic resources, although three of the families were receiving fairly intensive in home support and case management services through the child welfare system.

Child Profiles

All names have been altered to protect the privacy and to respect the confidentiality of the children involved in this practicum. Personal circumstances have also been altered to protect their identity. The resultant profiles are based on self-reported and referral information. The group membership included the following children:

Joseph was an eleven-year-old Aboriginal male child who was referred to the program by his Child and Family Services social worker. At the time of the referral, Joseph was living with his mother, his step-father and his two siblings. Approximately five years earlier, Joseph and his siblings lived with their mother and their biological father. During this time period, the children were witness to chronic verbal and physical abuse directed at their mother by their father. Joseph's parents were also dependent on drugs and alcohol. The parental violence and substance abuse significantly compromised the care that the children received and consequently, Joseph and his siblings were placed in foster care for approximately three years.

With support and counselling, Joseph's mother made significant changes in her life, including separating from her abusive partner and achieving sobriety. These changes resulted in the children being returned to the care of their mother and her new common-law partner. Despite the fact that Joseph was in a stable living environment and quite bonded to his step-father, Joseph was having behavioural problems. His

mother felt the problems were related to his exposure to violence, the loss of his father, and his time spent in foster care. More specifically, Joseph was struggling academically; he was getting into fights at school, and behaving aggressively towards his siblings. Joseph's mother was concerned that his aggressive behaviour was learned from his father, and she worried that without intervention, the behaviour would escalate and lead to more problems as he approached adolescence. Joseph's mother also acknowledged that his placement in foster care had taken its toll on their relationship and she hoped that the multifamily portion of the group would help them enhance their relationship.

Dora was a six-year-old Caucasian child who was referred to the group program along with her mother Sue, by their Child and Family Services social worker. The family had just moved to a new home to secure safety for themselves following a recent incident where Dora's father held Sue and the children hostage in their home over a 24-hour period. A no contact order was in effect, however Sue remained fearful for her family's safety. Prior to this event, Dora had been exposed to chronic physical, emotional and sexual violence perpetrated towards her mother by her father.

Sue presented in a state of crisis given the recent events and was struggling to manage the responsibility of caring for three young children as a single parent with limited supports and resources. Sue was particularly overwhelmed with Dora, who she described as defiant, hyperactive, and aggressive towards her siblings. Sue verbalized that Dora's behaviours were reflective of the violence that she witnessed. Unfortunately, she tended to be quite negative and blaming towards the child and she personalized many of Dora's challenging behaviours. It was apparent that Sue was in

need of intensive counselling regarding her experience of victimization and it seemed as though she would also benefit from additional supports and resources to assist her with parenting as well as other environmental issues such as housing and budgeting.

Initially, this family's suitability for the program was questioned. Dora's young age and developmental immaturity were the primary concerns. She presented with delayed speech, limited cognitive capacity, a short attention span, and hyperactive behaviour. Additional concerns centred on the crisis state that the family was in and on the mother's ability to focus on her child's needs and on their relationship, given that her own personal victimization had not yet been addressed. Despite these concerns, this family was selected to participate in the group based on the mother's insistence that she wanted to participate with her daughter and also because the child welfare agency that had referred the family was willing to provide in home services as well as other supports to the family in an effort to meet all of their needs.

Alex, a ten-year old boy, and his mother Ann were the third family referred to the group program by Child and Family Services. This Metis family was struggling in the aftermath of violence perpetrated by Alex's father towards his mother. The violence had been ongoing for several years and culminated in one serious event that left the family home in ruins and the father incarcerated for physical assault, damage to property, and uttering threats to kill. On the advice of child welfare, Ann separated from her husband, however she was ambivalent about leaving him and insecure in her role as a single parent. She presented as depressed with very low self-esteem, and she was having difficulty providing structure and limits in the home environment. Ann

was concerned about Alex as he missed his father and blamed her for the separation. Whenever Ann tried to talk to Alex about his feelings, he would become angry and aggressive towards her. Alex was also having difficulty in school both academically and behaviourally, which had resulted in two suspensions.

It was apparent that Ann and her children were in crisis due to the violence and the reconstellation of their family. In addition, this family was burdened with a multitude of other problems including financial debt, inadequate housing, and criminal proceedings. Ann and Alex were selected to participate in the group with a view that the program could offer support to the mother and provide an opportunity for Alex to process his feelings in a safe and supportive environment with other children who have had similar experiences.

Eight year old, *Shannon* and her mother Cara were self-referred to the group on recommendation from Shannon's school counsellor. Shannon's mother had recently separated from her husband due to physical and emotional violence, which had escalated in both severity and frequency over time. Shannon witnessed the violence on a consistent basis. Following the separation, the violence continued and resulted in the father breaking into the family home and strangling Cara in Shannon's presence. He was charged with attempted murder and incarcerated, however the family still lived in fear, knowing that he could be released. Cara expressed concern about how Shannon was coping with the violence that she witnessed and the break up of the family. Cara indicated that Shannon was presenting with extremes in behaviour. She was either sad and withdrawn or angry and aggressive. Cara was particularly worried about Shannon's self-esteem and her health, as she was overweight. Cara

wanted Shannon to receive support around her experience of witnessing violence and she hoped that she could rebuild the close relationship that she once had with her daughter through the multifamily group.

In reviewing the client profiles a number of similarities and differences were evident. The four families all had involvement, past or present, with Child and Family Services and one of the children had been in care due to the reported domestic violence within the home. Three of the families had been in shelter for a period of time due to the violence and two of the families had to relocate for safety reasons. With the exception of two families, members did not present as being in immediate crisis, although to varying degrees, the families were all struggling with other chronic stressors including criminal hearings, custody access disputes, and changes in employment and housing.

There was some diversity in the type of violence each child was exposed to, although in each family the perpetrator of the abuse was the child's biological father. All four of the children had been exposed to chronic parental violence, which included yelling, name-calling, threats, and physical assaults. Three of the children had been witness to 'severe' incidents of violence, for example one of the children witnessed her father break into the home and strangle their mother, while another child was held hostage by her intoxicated, knife wielding father. Joseph was the only child having contact with his biological father, although he as well as the other three other children, were all struggling with ambivalent feelings regarding their father's absence from the home. On a positive note, all of these children had mothers who removed themselves

from the violence through separation and/or divorce. Thus, these children had seen some resolution to the abuse, and had experienced a parent acting in their best interest.

The mothers of the children all shared a common concern for their children and how they were processing their exposure to violence. Additionally, all the mothers had concerns over the behaviours exhibited by their children. Some of the presenting behaviours included: aggressiveness towards siblings at home, lying, lack of progress in their schoolwork, daydreaming, stubbornness, and argumentativeness. Many of the women had questions pertaining to how much of their children's behaviours were related to the violence exposure directly and how much was related to the loss of their father in their lives. Each mother was also dealing with her own emotions concerning the violence and the associated loss and change in her life following their separation from her partner. Many of these women were unaware of the impact of violence on their children or else they tried to minimize it. They feared that if they talked about the violence with their children, it would upset them. Consequently, the four children selected for the group had not had any prior opportunities to express and identify emotions related to the violence they witnessed.

We would have preferred a larger number of children in the group, in anticipation of attrition, however, there simply were not enough referrals received to allow for this. In recognition that the small group size would require active participation, we stressed to the mothers that weekly attendance was very important. We also recognized that the wide age range between the children would require flexibility and creativity on our part, with respect to implementing the activities and facilitating the group dynamics. In summary, while there were some concerns about

group composition, we felt optimistic that the group could offer these children a nurturing environment to process their exposure to parental violence.

Planning

The planning for the group began several weeks prior to implementing it. This included meetings with my co-leader and clinical supervisor as well as the leaders of the mother's group to discuss the content of the groups and to review possible group processes that might occur in the group sessions. I also had to organize the group environment and create a space that was safe, warm, and inviting. This involved selecting a room large enough to allow for free play and other physical activities, using brightly coloured floor cushions, designating a "quiet area" with blankets and pillows for group members who felt the need to be alone, and ensuring the room would allow for privacy. Floor cushions were placed in a circular seating arrangement to promote interaction among the children and leaders. We decided to pre-assign the seating each week so that each child could take turns sitting next to the group leaders thus reducing conflicts.

Group Format

The group progressed for twelve consecutive sessions. Each session was one hour long, with sessions beginning and ending on time. Each module followed a consistent structured format that permitted the integration of the specific goals and objectives. Each session had a beginning, middle, and ending component, modeled after group developmental stages (Toseland & Rivas, 1995).

Given the importance of predictability in children's groups (Peled & Davis, 1991), group rituals were incorporated into each session so that the children would

feel a sense of safety and containment within the therapy environment. Accordingly, each session began with the leader offering an enthusiastic welcome and compliment to each child. For example, "Welcome Dora, we are so glad that you and your bright smile came to group today." The group then proceeded with a check-in where the children took turns identifying how they were feeling by pointing an arrow with their name on it to a feeling state, identified on a wheel. They were also given the opportunity to talk about anything that was relevant to their lives. This ritual allowed the children an experience of sharing and articulating their feelings. After this formality, the children were given a small snack such as crackers or a candy. Snack is considered very important to the group process as it provides satisfaction, nurturance and promotes social interactions among group members (Peled & Davis, 1995).

The theme of the week and structured activities followed the beginning rituals and comprised approximately twenty minutes of the session. Activities included stories about parental separation and family violence, a film about feelings, arts and crafts, body drawings, and puppet shows to demonstrate responsibility for violence. Session five was particularly significant in that the children drew a picture of fighting in their family and presented it to the group. The activities selected were related to the group's needs and abilities, and based on its stage of development. As group leaders, we recognized that children use play activities to reconstruct traumatic experiences (Nisivoccia & Lynn, 1999) and that the process was more important than completing the activities.

Following the theme based activity, the children were allowed to choose a Theraplay game to play, such as *tug of war*, S*imon says*, *balloon toss*, or *duck duck*

goose hug. These games helped to strengthen the cohesion between the children and relieve them of any negative emotions stemming from the previous activity. The final ten minutes of the session were reserved for closure and ending rituals. Ending rituals should help provide a sense of closure for children by offering them a chance to process issues that came up in the session (Peled & Davis, 1995). Accordingly, through a round robin format, each child shared what they enjoyed about the group. When they were done speaking they would pass a gentle touch to the person sitting next to them to signify it was their turn to speak. When this was complete the children's portion of the group was over and the children would wait for their mothers to join them for the multifamily group.

Analysis of the Group

Stage One: Getting Acquainted

In accordance with group theory, the tasks of this first stage are to set boundaries and establish the group structure, routines and rituals (Fatout, 1996). Other tasks include encouraging the children to bond, increasing their comfort and trust level with each other and the leaders, and forming a sense of group identity. It is also important to talk about feelings and to give the children the words to express what they feel, while continually reinforcing the view that the group was a safe supportive place for self-expression (Fatout, 1996).

When the children attended the group for the first session, they demonstrated a range of affect and behaviours. For example, Dora expressed feeling very excited about the group. She wanted to know what kinds of games we would play, she engaged in small talk with the other children, and she ran around the room shrieking.

Shannon on the other hand, presented as much more nervous and ambivalent. She was quiet and often looked down at the floor or scratched at her arms. She was also very compliant and polite to the leaders and other group members. Joseph asked numerous questions regarding how long the group sessions were, what activities were planned, and what the rules were. He stated that he would have preferred to be at home with his friends. The children also presented with what the literature refers to as "approach-avoidant" behaviours (Toseland & Rivas, 1995), meaning that the children advanced, trying to get to know each other, only to recede when it seemed too intimate. For example, Alex approached Joseph and asked him if he traded *Pokemon* cards. When Joseph said that he didn't, Alex quickly retreated to his pillow.

The children needed to understand that they each shared a similar reason for inclusion in the group. Accordingly, it was established for the children in this first stage that, "everyone in the group has had fighting in their family." This statement helped to set the tone for group and reduced feelings of shame for the children. They were also informed that the group was a place to talk about their feelings and they were reminded that they had permission from their mothers to talk about their experiences of witnessing violence. That being said, the children were not expected, or asked, to share any information concerning their exposure to violence during the first stage of group. This is consistent with the literature which suggests that disclosure in group should not take place until the children have developed an adequate level of trust in the group and the leaders (Graham-Bermann, 1992).

Dora did however disclose very detailed and graphic information about the violence that she witnessed in the first session of group. We validated Dora's

experiences of witnessing violence and modelled acceptance of her wish to talk about difficult family experiences. We were careful however, not to probe further, and instead established that we would be talking about fighting in families in subsequent group sessions. It would seem that Dora did not have a clear sense of appropriate boundaries around this issue, and thus it was important for her and the other children to understand when it was appropriate to talk about their experience of witnessing violence. The children were observed to be much more relaxed once the purpose of the group was clarified and after they were assured that they would not have to disclose any information about their family situation if they did not want to.

In this stage, group rules were established in a semi-democratic fashion to encourage the children to take ownership of the group and to increase their sense of safety. The children were asked to create and vote on a set of rules for the group, however we as leaders ensured that certain essential rules were established and that inappropriate rules were not. The rules of the group such as no throwing or hitting provided personal safety to each member. The privacy, pass, and no put downs rules created an environment of respect and emotional support. The children were then asked to sign their names on the rules poster as a means of empowering the children and establishing the contractual nature of the rules. All of the children seemed to agree that the rules were important to make the group a fun and safe place and their involvement in determining the rules seemed to have the effect of showing them that they had some decision-making power about how the group would be implemented.

Establishing these rules was also necessary to develop the norms of the group. The norms of the group appeared to have been established by the end of the third

session. The children understood the importance of being on time for each session, not bringing toys into the group room, and treating each other nicely. They were also aware of the importance of taking turns during circle time.

Enhancing each child's sense of belonging to the group was an important task during this stage. Group cohesiveness is very important for the success of groups for children of abused women, given that this population of children often feel vulnerable and perceive the world as an unsafe place (Peled & Davis, 1995). Accordingly, we implemented fun activities designed to get the children to know each other better. For example, in the first session, the children played *roller ball*, a game where each child rolled a ball to another child and then asked them a question, such as "what is your favourite food?" In another session we played a game of *hot potato*. In this game, the children passed a ball around the circle to music. The child left holding the ball when the music stopped was asked a feeling related question by the group leaders. The leaders provided supportive feedback and offered praise when group members took risks in verbalizing and expressing their thoughts and feelings. This game seemed to stimulate enthusiasm in the children and served to help them talk about their feelings.

Overall, in this initial stage the children were cautious and ambivalent about the group. They were also compliant, took turns easily and listened quite attentively to each other. As the sessions progressed and the children became more familiar with one another and the structure of the group, some acting out was observed. In fitting with group development, as cited in the literature, this initial stage of politeness and emotional distance is consistent with the first stage of group development. The

children were testing out the emotional and behavioural parameters of the group to determine safety and limits (Toseland & Rivas, 1995).

Stage Two: Establishing My Place in the Group

During this phase, the group continued to build cohesion as all the children came to know one another and shared common tasks. In addition to interacting with the group leaders and with each other, each child began to develop an identity within the group. The children assumed various roles and there was also some jockeying for position and status among the children. The group dynamics that occurred in this phase seemed fairly consistent with group theory, which identifies this stage as marked by struggles for power and control (Fatout, 1996). Our role as group leaders was to continue building group cohesion and trust, to reinforce norms, and set boundaries (Fatout, 1996).

There was a natural hierarchy that evolved in the group, with Joseph being the oldest in the group, as well as within his family constellation. Joseph often volunteered answers first and he was able to organize the other group members when it came time to make group decisions. The leadership role assumed by Joseph could also be a detriment at times as he could be bossy, judgemental, and insensitive or impatient with other people's feelings. This could, at times, inhibit some of the other children from talking. It was clear that the other children looked to him for direction and approval. Shannon also demonstrated a leadership role at times, in that she frequently answered questions and was polite and helpful to the other members. However, Shannon was more passive in her approach and she seemed to lack confidence, which affected the influence she had on others. At various times

throughout the group, I spoke to both of these children privately about their role as leaders and the example they needed to set for the others. Both children took this seriously, with Joseph improving his behaviour and Shannon feeling more confident about the effect she could have on the other children. Both children seemed to enjoy the responsibility and role model expectations placed on them.

The leadership abilities displayed by these two children demonstrated the process of children striving to have and develop power. They both thrived on the feeling of being empowered and could at times take advantage of their position to control and hurt others. When the power was used constructively it greatly enhanced the group. It also provided both a teaching and a learning opportunity when it was used negatively.

Alex and Dora were the followers in the group and both of these children had difficulty listening and focussing on the activities and discussions. Alex in particular, presented as an instigator with several attempts to disrupt the group and to focus attention on himself. He was easily distracted and readily joined any of the other children in misbehaviour or negative comments. Dora also had difficulty attending and listening throughout the sessions. She frequently removed herself from the activities and remained in large part, on the periphery of the group. Dora also screamed and yelled on a fairly consistent basis, seemingly in excitement as opposed to anger. Dora's behaviour also did not appear to be attention seeking in nature; rather, it would seem that it was reflective of immature development and the fact that she had difficulty regulating her emotions. It is interesting to note that the home environments for Dora and Alex were both chaotic throughout the life of the group. I suspect that

their behaviours may have portrayed the lack of safety and security they were experiencing at home.

While all the children acted out to varying degrees, Dora's behaviour was significantly defiant (name-calling, play-fighting, shouting, not listening or participating) and proved to be very challenging for the group leaders. Dora did not respond to verbal direction and therefore she had to be physically redirected, e.g., group leader would take her by the hand back to the group. At times, the other children in the group would join in her misbehaviour, but more often they appeared annoyed, as the behaviour could be quite distracting. Shannon tried to connect with Dora on a social basis, but Dora was not interested and disregarded her attempts to connect socially. This was difficult for Shannon as the two boys seemed to form an alliance during this stage, likely due to their same gender and close age, and this left Shannon feeling left out and uncertain.

In many ways, this stage was most challenging as we struggled to find ways of managing the broad range of inappropriate behaviours demonstrated by Dora and the other children. We were aware that the group had not yet accomplished the purpose of defining and dealing with their experiences of violence. Consequently, we were concerned that that the power and control issues and the behaviours of the children were obstacles that could prevent the group members from accomplishing these tasks. The group needed to develop cohesion and work on issues of trust, however it was apparent that this might not occur unless we implemented a powerful intervention to help the group move into this challenge. Supervision became critical at this time given the emerging dynamics of the group. Through consultation, it was decided that

we as group leaders could respond to negative behaviour through ignoring, prompting and reminding about the rules, and/or using problem solving approaches. Our main plan however, was to focus primarily on any positive pro-social behaviour exhibited by the children through positive reinforcement. Given that this approach is most powerful when it includes a combination of labelled praises and tangible rewards (Schaefer, Jacobsen & Ghahramanlou, 2000), we complimented the children for good behaviour and then rewarded them quietly and spontaneously with a jellybean. These treats were offered on a sporadic basis to all of the children, but primarily to Dora whose behaviour was the most problematic. For example, Dora was very quiet and attentive during a movie about feelings. I told her that she did a good job of listening and rewarded her with a jellybean. This intervention proved to be quite effective, and over time, significant improvements were noted in her behaviour. In fact, my co-leader noted that Dora became almost like a "different child." She was referring to the fact that as Dora's negative behaviour diminished; many positive characteristics emerged, including a silly sense of humour and the capacity to be helpful and to listen.

After the behavioural problems and power and control issues had dissipated, there appeared to be a strengthening of group cohesion. An example was when the children began their own ritual of building a fort together out of pillows to hide themselves while waiting for their mothers to come join them for the multifamily group. The children started doing this in the second session, however they each hid behind their own pillow and often argued about who got to hide behind which pillow and in what corner. In the fourth and subsequent sessions, the children worked cooperatively to build one big fort for all of them to hide behind together.

Additionally, the children were observed helping one another and reminding each other of the group rules.

Clearly, the group was learning to work together. Although the tensions and distracting behaviours had not totally dissolved, the group was feeling safer for the members and mutual aid was developing.

Stage Three: Working on my Goals and Those of Other Members

Ideally, in this stage the children will feel a sense of belonging and safe enough to open up and share with the group some of their personal experiences of witnessing violence at home (Graham-Bermann, 1992). Activities and discussions are focussed on violence which allows the children to examine some of their thoughts and feelings regarding their exposure to violent events, to get support for them, and to learn about the witnessing experiences, feelings, and thoughts of other group members.

By this time in the history of the group, we as leaders had established a working relationship with the members. The children had already begun the process of disclosing and discussing violence related issues, and had experienced support and comfort from the group. As such, we believed that the children were now able to risk more about themselves and their experiences with violence. An exercise designed to facilitate the children breaking the secret of violence in their family was to have them draw a picture of a violent incident and then present it to the group. The others in the group could then offer support in the form of sharing a similar experience.

When Alex presented his picture to the group, he was visibly nervous. He stared blankly at the other children and had difficulty articulating what was happening

in his picture. The other three children encouraged Alex by telling him not to be scared. They reminded him that it was okay to talk about "bad things" that happened in his family and told him that, "it happened to us too." In an effort to promote this evolving mutual aid among the group members, we as leaders made a conscious effort to "step back" to allow the children to facilitate the discussion and to help one another. That being said, this exercise appeared to be much too threatening for Dora, who presented as very excited and anxious. She was unable to bind her anxiety through drawing or discussion and appeared to be "spilling" by talking excessively and in a pressured way about a time that she had witnessed her father threaten to kill her mother and brother with a knife. Since she was unable to contain herself and because the other group members could not ease her anxiety through mutual support, we helped her to calm down when she could not do this for herself. The calming down was facilitated by removing her from the group, by taking her aside, and by speaking directly about how upset she appeared. Further, the group leaders roles were now expanded to include calming down those who were anxious, as well as protecting the group from the intense emotion of particular members. Through this process, the children could see that even the most difficult of feelings could be identified and discussed.

As the children began to share more of their feelings about violence during this stage, mutual aid increased, and group cohesion was enhanced. Several behaviours indicated that the children in the group had a shared group identity, that is, they saw themselves as belonging to this particular group and acted in unison. Most notable was the fact that the children became very supportive to one another. It was seen in their

attentive listening, not interrupting, and in voicing agreement with each other. This stage also had a very co-operative, social quality, even though (and perhaps because) some very traumatic events were discussed. For example, the children were often observed having fun, acting up and showing off to one another. When Joseph would get up out of his seat, others followed. When Dora acted silly, the other children joined her. The mood was often one of laughter and there seemed to be an infectious quality to the fun. On the other hand, there were also times where there was a contagion of negative affect. This was seen as anxiety, or anger, and physically acting out to distract oneself and others from their intense, negative, feelings.

Stage Four: We Prepare Ourselves and End the Group

The focus of this stage is on termination and endings. The children need a way of separating which allows for the expression of their many feelings about being in the group and ending the group (Fatout, 1996). Allowing the children to be in control of some of the process of separation is crucial given that many events in their lives have been very much out of their control. In addition, because children who have been exposed to violence have lived their lives in secrecy, they can be confused and fail to learn healthy communication and social skills. The result can be anger, frustration, and an inability to get their needs met by others around them. This stage also presents an opportunity for the children to explore their thoughts and feelings around relationships with others outside of their families and to learn social skills, which ultimately can assist them in forming and maintaining healthy relationships with peers. Activities in sessions eleven and twelve included planning and having a party, reviewing all the

sessions and lessons learned, and making a gift for their mothers. Overall, the process reflected a review of the life of the group.

Some children managed the task of separating better than others. Joseph and Alex for example, mocked their own feelings by fake crying and snickering at the thought of feeling upset. Shannon and Dora on the other hand, were genuinely hurting, as evidenced by their clinging to group leaders and saying that they did not want the group to be over. Leaders used the opportunity to educate the children about the dual nature of feelings when groups end. We spoke of ambivalence, feelings of relief and sadness. Rather than diminishing the experience by claiming only one extreme feeling such as hating the group and being glad that it is over, or loving the group and never being able to live without it, we helped the children to recognize and allow for the existence of mixed feelings. Once again, it was hoped that skills learned in the group would be generalized to other similar situations. In this instance, it was hoped that the children could learn to identify their feelings of loss associated with leaving the group and that these skills would be used to manage feelings when other endings, separations, or losses occurred.

Celebrating the group's accomplishments also marked this stage. A small party for the children and their mothers was planned for the final group session. The children had cake and played all of their favourite games and they presented their mother with a handcrafted terracotta plant pot and flower to symbolize their healing and growth throughout the group process. Each parent and child also received a certificate for completing the group. Most of the families seemed to enjoy this final session, however it was noted that Dora and her mother both struggled with their

emotions. After they were presented with their certificate, mother and daughter engaged in a power struggle over who would hold it. The conflict escalated to the point where Dora swore at her mother, which caused her mother to leave the room in tears. I suspect that the conflict between Dora and her mother was precipitated by the high degree of anxiety that both felt over the ending of the group. This was processed with them individually and together. Both admitted that they did not want the group to end. Dora's mother expressed feeling that she needed ongoing support and we assured her that we would continue to work with her post group to ensure that she had appropriate resources in place.

Following the final group session, we met with our clinical supervisor and the leaders of the mother's group to discuss our own feelings of loss and relief, both of which were considerable. In addition, concern for the welfare of particular children was expressed and plans were made to offer further intervention to them and their families. For example, we arranged for Alex's mother to attend the group again with Alex's older brother and we recommended to Child and Family Services that they continue to provide in-home services to Dora and her mother.

Evaluation

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

Joseph

On the CBCL Joseph's T scores pre- and post-test for Internalizing Problems increased from 53 to 60, Externalizing Problems dropped from 63 to 58, and Total

Problem increased from 55 to 58 (See Table 1). Both pre-and post-test scores remained in the normal range for Total problems. These T scores seem to suggest that Joseph did not present with clinically significant emotional or behavioural problems at the onset of group, and that the group intervention produced little or no change in these areas.

The CBCL pre- and post-test findings fit with my clinical observations of Joseph. While Joseph did at times present with hyperactive behaviour, he was not overly challenging throughout the group. He appeared to be compliant to his mother's direction and did not demonstrate any significant behavioural problems throughout the course of the group. Joseph not presenting with symptoms in the clinical range may be reflective of the fact that the violence he witnessed had occurred several years earlier and at the time of the group he was feeling safe in the care of his mother and step-father. There is no clear explanation with regards to why Joseph increased in internalizing behaviours, specifically around somatic complaints and anxiety. However, because the subject matter we discussed in group was sensitive and emotional, it is possible that Joseph's participation in the group raised stressful feelings for him related to the violence that he witnessed in the past. This is consistent with the literature, which suggests that the mere existence of the group in the lives of children, which requires them to confront and rethink violence-related issues, can produce worrying emotions (Peled & Davis, 1995). The slight decrease in externalizing behaviours may suggest that Joseph's mother perceived him as more manageable after the group but more than likely reflects simple measurement error.

Table 1

T Scores for the Child Behavior Check List at Pre- and Post-Test for the Group Intervention

Group Member		Internalizing	Externalizing	Total Problem
Dora	Pre-test	73	87	81**
	Post-test	64	83	72**
Joseph	Pre-test	53	63	55
	Post-test	60	58	58
Alex	Pre-test	60	69	65**
	Post-test	70	74	72**
Shannon	Pre-test	63	62	62*
	Post-test	39	52	45

Note:

* Indicates a borderline, clinically significant score on the Total Problem Scale (between 60 – 63).

** Indicates a clinically significant score on the Total Problem Scale (above 63).

Joseph's scores on the PHCSCS fluctuated on all six-cluster scales. His scores decreased for Behaviour and Intellectual and School status, his score remained constant for Popularity, and his scores increased on the Physical Appearance, Anxiety and Happiness and Satisfaction scales. His total T scores from pre- to post-test went from 66 to 65, suggesting that there was minimal change. Despite this, it is important to note that Joseph's self-concept, pre-and post intervention, remained in the average range (See Table 2).

The findings related to Joseph's self-concept were not consistent with my clinical observations. Throughout the group, Joseph presented himself as a very confident, self-assured child. He emerged as a leader in the group and had an easy time completing the tasks and activities. Given this, it is not clear what accounted for the decrease in his self-concept. It is possible that Joseph was dealing with issues outside of the group context, and these issues may have influenced his scoring. That said, the post score change is quite insignificant and therefore any interpretation needs to be done with caution.

Results from the post-group children's interview indicated that Joseph enjoyed coming to the group. He particularly enjoyed the games that required challenge and skill, such as *feelings basketball.* In particular, Joseph liked the time that he got to spend with his mother in the multifamily group. Joseph said he would recommend the group to his friends and he said that he wished the group could have been longer. When asked if there was anything he would change about the group, Joseph

Table 2

T Scores for the PHCSCS Pre- and Post-Test

		I	II	III	IV	V	VI	Total
Joseph	Pre-Test	54	70	64	52	55	52	66
	Post-Test	47	63	69	63	55	63	65
Dora	Pre-Test	36	59	60	55	61	56	53
	Post-Test	66	59	64	69	61	63	74
Alex	Pre-Test	45	63	49	63	47	42	52
	Post-Test	59	70	69	59	47	52	56
Shannon	Pre-Test	66	55	53	52	55	56	62
	Post-Test	66	70	69	69	69	63	80

Note: Cluster Headings: I = Behaviour, II = Intellectual & School Status, III = Physical appearance and attributes, IV = Anxiety, V = Popularity, VI = Happiness and Satisfaction.

* Indicates a clinically significant score on the total problem scale (below 44)

commented that he wished there were not so many "babies" in the group and he also wished that the group was just for boys. Joseph's mother expressed that she enjoyed the individual time that she got to spend with her son during the multifamily group. She said that she noticed positive changes in Joseph after the group. In particular, she said that Joseph was sharing with his siblings and peers and listening to her more.

Dora

On the CBCL Dora's T scores pre-and post-test for Internalizing Problems decreased from 73 to 64, Externalizing Problems decreased from 87 to 83, and the Total Problem scale decreased from 81 to 72. As noted in Table 1, both pre- and post-test scores remained in the clinically significant range, however a fairly significant decrease did occur.

These findings are consistent with my impressions of Dora. As noted previously, concerns were raised initially about Dora's suitability for the group given that her mother was in crisis and because Dora was experiencing serious emotional and behavioural problems. As predicted, Dora's behaviour was quite challenging throughout the group, however as the group progressed and behaviour management techniques were implemented, improvements were noted in her behaviour. Additionally, with the support of the parallel mother's group, Dora's mother appeared more relaxed as the group evolved. It was my clinical impression that Dora appeared more settled when her mother presented as managing better. Overall, it would seem by the scores that Dora and her mother did benefit from the group intervention. While Dora showed marked improvements in her behaviour she still presented in the clinically significant range at the end of group. I think that this reflects that fact that

this mother and child endured several years of extreme violence and were in significant transition at the time of the group. I think it would be unrealistic to expect more significant positive changes, given all the barriers in this family's life. Also, it is important to note that this family was also receiving services from Child and Family Services, including an in home support worker. Therefore, the group intervention alone was not the sole positive influence on this family and cannot account for the changes.

Dora's total T scores for the PHCSCS went from 53 to 74, indicating a significant increase in her self-concept. Dora's score on the Intellectual and School Status subscale remained constant at 59, as did her score on the Popularity scale, which was 61. On the remaining five scales, her scores showed an increase. On the Behaviour scale she scored 36 at pre-test and then 66 at post-test. Her score climbed from 60 to 64 on Physical Appearance, from 55 to 69 on anxiety, and from 56 to 63 on Happiness and Life satisfaction.

Dora's pre-test total T scores suggests that she had a healthy self-concept prior to the group, however the significant increase in her score at post-test seems to indicate that the group intervention enhanced her feelings about herself. As mentioned, Dora presented with very difficult behaviour at the beginning of the group. As these behaviours subsided over the life of the group, Dora's positive characteristics, which included a sense of humour, playful nature and spirited personality, emerged. The other children in group, as well as the leaders were subsequently able to engage with Dora and she received much positive attention for her dramatic antics in the group. I suspect that this may account for the sharp positive

increase in her score. Additionally, I observed in the multifamily group that Dora's mother began to relate to her in a more positive, nurturing manner. Thus, the increase in Dora's self-concept could also be correlated with the strengthening of her relationship with her mother. Dora's scores on the PHCSCS need to be interpreted with caution. Given that the Piers-Harris scale is designed for children 8-18 years old and because of Dora's young age and immaturity level, the validity of the scores are questionable. That said, there were no concerns noted on the validity index

In the post group interview, Dora said she loved coming to the group and was very sad that it was over. Her favourite activity was *Duck Duck Goose Hug*. Dora said that there was not anything that she disliked about the group. Dora's mother was very positive about the outcome of the group. She commented that Dora's behaviour had improved significantly since the group and she felt that her relationship with her daughter had been strengthened. Dora's mother felt that the group was too short and expressed concern about whether the changes in her daughter and their relationship would be sustained in the long-term.

Alex

On the CBCL, Alex's pre-and post- test scores for Internalizing Problems increased from 60 to 70, Externalizing Problems increased from 69 to 74, and Total Problem scale increased from 65 to 72. At pre- and post-test, Alex presented with scores in the clinically significant range. These T scores suggest that the group intervention did not have much of a positive effect in changing Internalizing and Externalizing Problems (See Table 1).

These findings fit with my clinical impression of Alex. His behaviour was very challenging throughout the group, perhaps even more so as the group evolved. For example, Alex often tried to distract the other children, he had difficulty attending and listening and he often seemed to dissociate during group activities or when group leaders tried to address an issue with him. I suspect that Alex's behavioural problems and the increase in his T scores reflect the fact that his mother was experiencing chronic and severe stress throughout the group. This family was burdened with a multitude of problems including housing, financial, parenting, and maternal depression. Because basic needs were not met for Alex or his mother, it is possible that he was not able to focus on the material presented in the group. Furthermore, the lack of positive changes reported at post-test could be a reflection of Alex's mother's perceptions that old problematic behaviours were being replaced by new problematic behaviours, or the possibility that Alex's behavioural problems exacerbated the stress which his mother chronically experienced throughout the group.

On the PHCSCS, Alex's scores indicated that he possessed a favourable self-concept. His total T score increased from 52 to 56, suggesting that his self-concept improved following the children's group. In particular, he showed improvement on all the subscales except for two. His scores increased on the Behaviour scale from 45 to 59; on the Intellectual and School Status scale from 63 to 70; on the Physical Appearance scale from 49 to 69, and on Happiness and Satisfaction from 42 to 52. Alex's score decreased in the area of Anxiety from 63 to 59 and his score remained constant at 47 on the Popularity subscale.

These findings only partial fit with my impressions of Alex. This is because Alex was going through some serious family crisis while in the group, including a move to a new school. Given that his mother was depressed and overwhelmed in her parenting role, I assumed that the positive attention Alex was receiving at home was minimal. In addition, because this family was quite isolated in their community, opportunities were limited for Alex to receive support from others. At the same time, Alex did talk about himself in positive terms and he did indicate in the group that he was feeling settled in his new school and making friends. It is not clear what accounted for the drop in his score on the Anxiety scale. His positive scores may suggest that even though he was enduring many changes in his life, he was still getting some of his emotional needs met.

In the post-group interview, Alex said that the group was "okay." He had difficulty articulating any particular likes or dislikes about the group but did say that he would recommend it to his friends. Alex's mother said that she was continuing to struggle with Alex's behaviour. She said that she had noticed very little change in his aggression and hyperactivity. She also said that she was feeling depressed and overwhelmed with the demands of her parenting and household responsibilities. This particular family was continuing to receive support and service from a child welfare agency and a decision was made for the mother to participate in the group again with her older son.

Shannon

On the CBCL, Shannon's pre- and post- test scores for Internalizing Problems decreased from 63 to 39, Externalizing Problems decreased from 62 to 52, and Total

Problem scale decreased from 62 to 45. At pre-test Shannon's scores were within the clinically significant range, whereas post-test they were within the normal range. For Shannon, these findings suggest that the group intervention had a significant positive effect in decreasing both Internalizing and Externalizing behaviour problems (See Table 1).

With respect to Shannon, my clinical impression partially fit with the results of the measure. During the assessment, my impression was that Shannon was a child experiencing a range of internal problems such as anxiety and worry. I was surprised to learn that she was also demonstrating Externalizing problems in the clinical range. The significant decreases in the scores for Shannon suggest that she did benefit from the group and I would concur that this is consistent with my observations. Shannon was very compliant throughout the group and seemed to be an adult pleaser. Accordingly, Shannon listened and participated to the fullest. It was also apparent in the parent child group that Shannon and her mother were enjoying the parent-child time together and I suspect that this had a significant impact on how Shannon's mother perceived her behaviour, thus accounting for the significant improvements in her scores.

Shannon demonstrated through her scores that she is a child with a good self-concept. She remained constant with a score of 66 on the Behaviour scale, but otherwise increased on all of the other subscales. On Intellectual and School Status she went from 55 to 70; on Physical Appearance she went from 53 to 69; from 52 to 69 on Anxiety; 55 to 69 on Popularity, and 56 to 63 on the Happiness and Satisfaction scale.

My observations of Shannon indicated that she was a child demonstrating primarily internalizing behaviours and therefore I expected her pre-test scores to be somewhat lower. At the same time, it was also very apparent that Shannon shared a close relationship with her mother. She demonstrated throughout the parent-child group that she had the capacity to be very loving and nurturing towards Shannon. This may account for her elevated scores at post-test. In addition, because Shannon is a very complacent, likeable little girl, it is also possible that she was able to get some additional validation of her worth through the school system or from extended family members.

Shannon expressed positive regard for the group in her post group interview. She said that she enjoyed hearing the stories about family violence and she liked making "slime." Shannon said she would recommend the group to her friends, but only if they had witnessed violence. Shannon also said that her favourite part of the group was spending time with her mother in the multifamily group. Shannon's mother commented that Shannon seemed to have more confidence after the group. She talked about her feelings more readily and she was presenting with fewer emotional outbursts. Shannon's mother said that she felt the group enhanced her relationship with her daughter and she was appreciative that she had the opportunity to participate.

Summary of Evaluation Results

The children's score on the CBCL varied quite significantly, which perhaps is not surprising given the variability in children's functioning that can exist among children exposed to parental violence. Elevated scores do support the various studies

that report parental violence to harm children in emotional and behavioural areas of functioning (Jaffe et al., 1990; Peled & Davis, 1995). Furthermore, it should be noted that in addition to the exposure to parental violence, the children with elevated scores had mothers who were in crisis. Because the CBCL is based on subjective parental perception of children's behaviour, this factor alone, could also account for the elevated scores.

In general, it is difficult to determine what factor(s) caused the changes in the post-test results. The pre-test / post-test design utilized for this practicum is quite limited in the sense that it cannot isolate the specific variables responsible for the changes. For example, it is not possible to determine whether the multifamily group had a greater impact on the children, then the individual children's group. Alternatively, because children's behaviour often mirrors parental coping, the children's scores could have been more a reflection of how their mothers were managing. In addition, many of these families were involved with outside agencies and resources and therefore it is possible that the children were influenced by factors outside the group context. Therefore, although the psychometric properties of the CBCL are strong, the findings must be interpreted with caution.

In regards to the PHCSCS, one would expect that the children's self-concept would increase as a result of the group intervention. Thus, since the scale is scored in the direction of positive self-concept, it would be expected that post-test scores on the cluster and total scales should be higher than pre-test scores. Examining the figures reveal that, as expected, most post-test scores are higher than pre-test scores. However, as consistent with the CBCL, it is difficult to determine which factors

caused the changes in the post-test results. Whether the changes resulted from the group intervention or other factors is not known.

The feedback that was received from the children, both in the written client satisfaction questionnaires and verbally in the post-group interview gave important data for evaluating the intervention. Overall, the children reported positive outcomes resulting from the intervention and satisfaction with their experience. They all understood that they were there to talk about feelings. Some of them wanted more time to talk about their individual feelings, some wanted more time to play, and all of them loved snack and the good behaviour reward jelly beans! Two of them said they would recommend the group to a friend, while two of them said they would not. This could well be a function of the wording of the question, which read "I would recommend this group to a friend", but should have read, "I would recommend this group to a friend who has witnessed domestic violence." Given that children are very concrete in their thinking and consistent with being like their peers, most of their friends had not experienced witnessing parental violence, so would not be interested in a group that was specifically formed for the purpose of talking about violence in families. The mothers of the children seemed to echo their children's positive feelings about the group. In particular, the majority of the mother felt that the group had influenced their children's behaviour in a constructive manner. In addition, the mothers appreciated the time that they spent with their child in the multifamily group and felt that their relationship with their child had been strengthened as a result.

Conclusion

The purpose of this practicum was to develop, implement, and evaluate a group for children who had been exposed to parental violence. The results of the CBCL and the PHCSCS suggest that group provided a beneficial intervention for the children. Although the standardized measures reflect the positive changes to have been moderate, the Client Satisfaction Questionnaires and post-group interview feedback received suggest that the group was a positive experience for the children and their mothers with beneficial outcomes being described.

It is also useful to consider the implication of this evaluation within the context of these families' ongoing therapeutic needs. For example, Shannon and her mother had accessed family counselling for themselves and the three other families were receiving support and service from child welfare agencies. In this regard, this intervention could be considered a beginning process for these families.

The children in the group crossed the two developmental stages of middle years and pre-adolescence, with the youngest child being six, and the oldest child being eleven years old. Many times varying levels of thinking and understanding were present. The older children were able to reason through more abstract thought. They could identify and express feelings, whereas the youngest child could not. For example, Dora was able to describe in detail the violence that she witnessed, however she had difficulty grasping abstract issues such as blame and responsibility with the degree of maturity and sophistication as the older children. She could only tolerate discussion of these topics for very limited periods of time before initiating some distracting behaviour. This created some disharmony at times, as the children were

able to withstand different levels of intensity and comprehend with different levels of understanding during our group discussions. It should be noted however, that the older children also engaged in disruptive behaviours either when they were bored, or when the emotional intensity was too great for them to feel comfortable.

In considering whether to have a smaller age range I feel that the mix of children in the group provided a heterogeneity that was helpful in the group process. The older children provided a good role model for the younger children, and in general they needed less direction and attention from group leaders. The younger children in the group, Dora in particular, were less guarded about expressing their feelings and discussing their experience, in such a manner that they challenged the reticence of the older children to self-disclose. The younger children also provided an opportunity for playfulness that helped deflect the emotional intensity of the group. In this sense, there appeared to be a good balance between the developmental stages. Age differences are seen quite naturally in families where children must relate to each other in everyday situations. In the safety of the group the different perceptions and understandings could be clarified and discussed.

The literature on group work suggests an optimal number for a treatment group should be about six to eight children (Peled & Davis, 1995). In keeping with this suggestion we targeted this number for group membership. Although we had many suitable candidates for the group, only four children were selected for participation. Although, unplanned, it would seem that the small group size had a positive impact for the children and the multi-family group. With respect to the children's group, the small group size appeared to contribute to the cohesion that developed and it was also

helpful to the group leaders in term of managing behaviour. The smaller group size was also advantageous to the parent-child multi-family component. For the members the small size provided an atmosphere conducive to increased sharing amongst families that allowed for intimacy and cohesion.

The group developed through a sequence of four stages, whereby the children became more confident in testing limits as they became more familiar with the leaders and with each other. They also tested limits more as the emotional content became more intense. Accordingly, a theme that emerged from the group involved the need to set clear, fair rules and limits, given that the children were not mature enough to impose appropriate social behaviour consistently on themselves. They needed the adult authority to define and enforce the limits. To this end, the group was structured and primarily leader led with the children responding to that leadership. At the same time, despite the structured format, the group was more process- than content-oriented. The activities introduced possible issues, but what happened in the group depended primarily on the material provided by the children.

Group cohesion did evolve over time, however my impression is that the interactions between the children were primarily superficial, with no strong friendships developing between participants. The fact that there was a wide age range may have contributed to the lack of relationship development between group members. The experience of witnessing violence was the main thing these children had in common and this was a major factor that enhanced group cohesion. The children were observed to influence each other in the group. As leaders, we were often

struck by the support the children offered to one another when talking about shared experiences.

From my perspective as a group leader, I found the group intervention to be both rewarding and challenging. Finding ways to manage the broad range of behaviours that emerged in the group sessions was perhaps the most time consuming and emotionally taxing aspect of the group. In order to address certain behaviour, we first needed to understand the underlying motivation, however this was difficult given that there were limited opportunities to spend individual time with the children. As a result, clinical supervision became crucial to the process. Supervision sessions were held weekly and included the program manager as well as the leaders for the mother's group. In these supervision sessions, discussions took place around the functioning of the children as well as their mothers and information was shared in terms of what was happening in each family's life. This information allowed us as group leaders to place the children's behaviour within a context and interventions were then developed accordingly. For instance, a spontaneous reward system of offering jellybeans to the children when they demonstrated a positive behaviour was implemented and proved to be quite effective.

For some families, parallel changes did not always occur between parent and child. For example, Alex's mother was quite depressed and overwhelmed throughout the group and Alex's progress in the group may have been hindered by what was happening with his mother and in his home environment. The group therefore highlighted the importance of maintaining a systems perspective whenever one is offering intervention with children. In Alex's case, the leader for the mother's group

offered individual counselling to the mother above and beyond the group sessions and meetings were also held with external agencies to discuss other supports that could potentially benefit the family outside of the group context

Observing the children play and have fun, despite their traumatic family history and current struggles was extremely rewarding. In addition, facilitating the bond between the children and their caregivers was a very powerful experience. I was reminded that parents are the most influential role model in a child's life and how children can thrive if this relationship is nurtured. In summary, the group experience provided valuable learning and insights, particularly regarding the importance of clinical supervision, the need to be flexible and to focus on process, and the value of working collaboratively with parents and others in the community for the best interest of the child.

CHAPTER FIVE-THE INDIVIDUAL INTERVENTION AND ANALYSIS

Client Overview

In total, two children engaged in individual therapy with me as the therapist at the Elizabeth Hill Counselling Centre. Initially, I had planned to provide individual therapy to three or more children as part of the practicum experience, however because working with the parents of these children was to be an integral part of the treatment process, it was determined that working with two children would be adequate. Fortunately, I had the experience of working with two very different children, which provided an opportunity for enhanced skill development. Although similar in age, the two children differed in terms of their gender, life experiences, and symptoms. The first child was female, had been raised in a home with parental drug abuse and violence, and was experiencing internalizing behavioural problems. The second child was male, had grown up in a home with violence and divorce, and was displaying externalizing behaviours. The two cases are expanded upon in greater detail below.

The Case of Brittany

Presenting Problem

Brittany is a ten-year-old child who was referred to the Elizabeth Hill Counselling Centre by her mother Nora for individual therapy. Brittany was raised in a home where she witnessed chronic abuse directed towards her mother by her father. Brittany and her younger sibling were also subjected to multiple moves across provinces, poverty, and serious maternal drug use which at times resulted in abandonment and placements in foster care. At the time of referral, Brittany was in

foster care with her Aunt. Brittany's parents were divorced and her mother had just completed a residential treatment program for cocaine addiction and she claimed to be clean and sober. Nora recognized that she had subjected her children to a very unstable home environment over the years and she expressed a commitment to become a more responsible parent and eventually to be reunited with her children.

Nora requested therapy for Brittany upon the advice of her Child and Family Services social worker, however, she was uncertain as to how therapy could help her daughter. Nora was unable to identify any specific or overt behavioural problems demonstrated by Brittany, and in fact, Nora described Brittany as a quiet, responsible child who did well in school. Nora did note however, that Brittany had a tendency to avoid any discussions related to her feelings. Brittany also seemed to worry a lot about her mother and when they visited together, Brittany would act as though she was the parent instead of the child. It was Nora's desire that Brittany have the opportunity to express her feelings and learn coping skills. She feared that without this early intervention, Brittany would be at risk for using drugs when she entered adolescence and/or would end up as a victim of abuse in her adult years.

It should be noted that Nora presented as a highly intelligent woman, with significant insight into the impact that her drug use, lifestyle and relationships had on her children. Nora's motivation to help her daughter work through her feelings seemed genuine, however, it was apparent that Nora was still in the early stages of recovery and thus the potential for her to relapse was high. Beverly James (1989), writing specifically about the treatment of traumatized children, advocates direct involvement by a parent or caretaker in a child's treatment, although she notes that clinical

discretion is needed to determine the degree of involvement. In this case, it was deemed important for Nora to be involved in Brittany's treatment, however it was also acknowledged that her primary focus needed to be on her own recovery and addiction after care plan.

Preliminary Assessment

Initial impressions of Brittany suggested that she was a mature and insightful child who presented as much older than her chronological age. She presented as bright and articulate and she demonstrated sophistication in her ideas and language. Academically, she was one of the top students in her class, and socially she had some friends and was involved in school activities and sports. Despite the pervasive history of parental drug abuse, abandonment, and violence, Brittany appeared to be functioning relatively well. On the surface, she seemed to be a well-adjusted child and was not demonstrating the kind of behaviour which sees children being sent for therapy, nor that which gets them into trouble with their parents or in the community.

It was apparent that Brittany possessed many characteristics of resilience as described in the literature (Hughes et al., 2003), however, she was also demonstrating some subtle internalized behavioural problems, such as withdrawal, emotional constriction, anxiety, and nightmares. Brittany's Aunt was interviewed as part of the assessment process and she noted that Brittany was frequently complaining of stomachaches and headaches. In addition, Brittany was insistent on taking on many of the household and parenting responsibilities within her Aunt's home. Brittany could also be quite bossy towards her younger brother and to her cousins, which often led to arguments. Furthermore, the Aunt noted that Brittany seemed to withdraw after being placed in her care. She stopped associating with friends outside of the school context

and she was spending large amounts of time alone in her room. When adults attempted to talk to Brittany about her feelings, she would consistently report that she was happy. She minimized and denied the impact that the parental substance abuse and violence had on her as an individual and her family as a whole. She presented as fiercely loyal to her mother, and spoke of her only in positive terms.

These symptoms as described above seemed to reflect a pattern of behaviour that Brittany developed in response to growing up in a home characterized by fear, neglect, unpredictability and inconsistency. This would be in keeping with the research of Claudia Black (1982) and others who have showed that in addicted and violent families, there are several survival roles to which a child may ascribe in order to accommodate to a chaotic situation (Ficaro, 1999; Jaffe et al., 1990). These roles are the result of unmet needs by the adults in an unhealthy family system. In order to maintain the family homeostasis, the children in these families take on behaviours that meet the needs of the system. Role reversal, for example, is common among children in substance abusing and also in violent families (Black, 1992; Ficaro, 1999; Jaffe et al., 1990).

As the oldest child, Brittany became the *responsible one* in the family (Black, 1982). She took charge of the environmental structure in the home and in doing so, she provided consistency for herself and the others. For example, Brittany completed the majority of the household chores and parented her younger brother. Because structure and consistency were not provided to Brittany by her parents, she found ways to provide it for herself. The adult role that Brittany assumed allowed her to be in charge, or at least feel she was in control; whereas, without it, Brittany would likely

have experienced a sense of losing control and being overwhelmed. Brittany also took on the role of a *placater* (Black, 1982). She tried to cope with her circumstances by denying her own feelings, and focussing on lessening the sadness, fears, angers and problems of her family members, in particular her mother.

These roles assumed by Brittany were functional to a degree, however, they extended outside the family context, and placed an enormous amount of pressure on her, thus contributing to her symptoms and preventing her from engaging in normal developmental activities, involving peers and having fun.

Another issue identified in the assessment was that Brittany was limited in her ability to reach out for emotional support. This was primarily because Nora had given Brittany clear instruction not to talk about private family issues, and also because Brittany did not believe that other adults would be available to help her. She learned early on that adults were not capable enough to provide any insight or direction for her personal life. Furthermore, if Brittany allowed herself to risk self-disclosure, she would have had to deal with her own reality, so I suspect that she became highly skilled at diverting attention from herself and repressing her feelings.

In summary, Brittany was a child who experienced pervasive loss on many levels. There was the loss of a healthy family system, of appropriate parent-child boundaries, and of childhood itself. There were many other losses as well, resulting from change of the family structure from separation, and abandonment by her mother and father. Brittany's experiences fostered a range of mixed feelings; however, because she was unable to express herself, these feelings often translated into psychosomatic complaints such as knots in the stomach, free-floating anxiety,

headaches, and sleeplessness. Brittany also learned from broken promises, shame, disappointment, and fear. Trusting adults became difficult for her, as did expressing feelings; therefore, denial, distrust, and the inability to feel became the mode of functioning for Brittany. Given the range of problems and symptoms experienced by Brittany, and the potential for them to extend into adulthood, treatment was indicated.

Treatment Plan

Brittany had been exposed to parental violence and therefore she fit the criteria for inclusion in the practicum. It was noted however, that this was a secondary issue for Brittany, and that her mother's addiction needed to be the focus of intervention. The treatment plan included twelve weekly play therapy sessions with Brittany, with each session lasting approximately one hour in duration.

Initially, I planned to maintain regular contact with Brittany's mother, however; early in the process she relapsed and retreated to the streets. Consequently, the focus of parental contact shifted to the Aunt, and she was offered counselling and support to help her in parenting Brittany. Unfortunately, due to her work schedule, the Aunt was unable to attend the Centre for regular meetings, however she did agree to weekly phone contact and to attend for in person meetings on occasion. I also maintained contact with the Child and Family Services social worker on an as needed basis, to assist her in case planning for Brittany.

Goals

Given the complex family history, Brittany's needs were often overlooked due to her mother's drug use. Thus by focusing intervention primarily upon Brittany, the ultimate goal was to encourage Brittany's healthy attitudes, beliefs, and coping skills

through therapeutic and familial support, and to provide Brittany with a nurturing, supportive context in which to feel safe and have fun.

Specific therapeutic goals included: (a) helping Brittany to develop a feeling vocabulary, (b) to express her emotions related to her mother's drug use and exposure to violence, (c) to enhance her coping skills, (d) to provide education regarding addictions and domestic violence, (e) to clear up cognitive distortions regarding feelings of responsibility and blame, and (f) to increase her self-esteem.

Therapy Format

The therapy sessions were primarily directive, although some elements of non-directive play therapy were also used. In each session, elements of Theraplay were incorporated to make the experience fun and enjoyable and structure was provided as a means of offering predictability and consistency. The first fifteen minutes of each session were devoted to check in, snack, and engagement activities. During check in Brittany was asked to identify how she was feeling and then asked to draw a picture to illustrate the feeling. Snack usually consisted of crackers and juice, and the engagement activity was always fun and lively. *Squiggle Tag*, for example, was a game we frequently played.

The next thirty-five minutes of the session focused on structured therapeutic activities related to the above stated goals. Some examples of these activities would be feeling games such as *Go Fish*, *Candyland*, and *Feelings Tic Tac Toe* which are all activities found in Liana Lowenstein's Creative Interventions for Youth (Lowenstein, 1999, 2002). I also engaged Brittany in discussions through puppet play. "Janie" the puppet often came to session to talk to Brittany about her feelings regarding her

mom's addiction to cocaine. I also used arts and crafts with Brittany as she particularly enjoyed doing this type of activity.

The final ten minutes of each session were devoted to a Theraplay activity or game of Brittany's choice. We would also do a brief closing where the theme of the session was reviewed and Brittany would be encouraged to focus on the good feelings that we spoke about in session and she would be asked to consider what she can do to feel better when bad feelings arise. By directing her in this way, it was hoped that she would develop positive coping strategies for the times when she felt stress or worry outside the therapy context.

Finally, in the last minute of the session, I would comment on Brittany's strengths and praise her for hard work. Brittany would then identify a positive attribute about herself and write it in a petal of a flower that had been cut out and pasted on a big piece of paper. This flower had twelve petals on it to symbolize the twelve sessions, and therefore in addition to highlighting Brittany's positive characteristics, it also served to assist with the termination process in that at the end of each session we counted how many petals were left on the flower. This termination preparation was important for Brittany given that she was sensitive to loss issues.

Therapy Process

The early work with Brittany involved developing the treatment relationship. Theraplay activities were utilized as a means of engaging Brittany and strengthening our relationship. Initially, Brittany presented as cautious and somewhat perplexed when these activities were introduced. It quickly became apparent that Brittany, as the responsible child in the family, did not know how to play or have fun. During the first

few sessions, she simply watched me play and was hesitant to join in. With encouragement however, and after Brittany became more relaxed and saw me acting silly and having fun, her resistance decreased and she participated fully in the activities. In fact, during a game of *cotton ball toss*, Brittany was laughing so hard, tears came to her eyes and she could not complete the activity! The Theraplay activities therefore served a dual purpose. They provided a means for me to engage with Brittany and they offered Brittany the experience of being a child, having fun, and escaping from the adult responsibilities and worry she was burdened with in her in daily life.

During the early sessions, Brittany's capacity to discuss her problems and worries was understandably quite limited. During check-in she consistently said that she was "fine" or "okay." She appeared ambivalent about sharing any negative or mixed feelings. Therefore, the first few sessions focussed on teaching Brittany to identify and distinguish the various feeling states, with a view that she could then be helped to communicate her own emotions. Several activities were used to assist in this process. For example, during check-in, Brittany was given a *Feeling Faces* chart to aid her in identifying how she was feeling. We also played *Candyland* and *Feelings Basketball* (Liana Lowenstein, 1999, 2002) to aid in the process. Having learned labels for various emotions, and ways to communicate them, Brittany was taught how to express simultaneous, conflicting feelings, and learned that it is acceptable to do so. She was also given the message that negative feelings such as anger would not cause her to lose her parent's love and that feelings are transitory, that is they change.

By session four, Brittany was identifying the presence of complex feelings at check-in, "I am feeling angry and sad today" and she seemed to appreciate that a range of feelings, including negative ones, were normal and okay for her to express. This was around the time that Nora relapsed, abandoning Brittany and the plan to work towards reunification. The relapse precipitated a crisis for Brittany and served as a catalyst for her to express her emotions regarding her mother's drug use. For the first time, Brittany expressed a range of emotions including anger, sadness, disappointment and frustration in regards to her mother's behaviour. To further help Brittany with this process, she was given the task of throwing clay "bombs" at a series of words and pictures, which symbolized her mother's drug use. Brittany was very emotional and intense when throwing the bombs, and she continued throwing them until she became tired. Afterwards she expressed relief and satisfaction that she was able to vent her feelings and have them validated. This activity seemed to be quite therapeutic for Brittany in that she was able to release anger that she had been repressing for many years in a safe and supportive context.

During the middle course of therapy, education was provided to Brittany about addiction and violence issues. Her understanding was that people who have an addiction, are "sick." Through the use of discussion, artwork, and workbooks, Brittany's knowledge base was expanded upon. More specifically, the concepts of addiction and violence were defined, the reasons why people use drugs or are violent were explored, and the impact that drug use and violence can have on children and families was discussed. Brittany was given the message that her mother's drug addiction and relapse pattern was a problem that was beyond her control, and that

despite her mother's addiction, she was still a good person and could achieve her own goals and dreams. This aspect of therapy seemed to be helpful for Brittany in that she came to recognize that her mother still loved her in spite of her problems and her inability to parent her.

Another part of the process involved addressing Brittany's feelings of blame and responsibility for her mother's addiction. Brittany expressed her perception, that "if my mom loved me, she would stop using drugs." Through discussion, Brittany's cognitive misconceptions were corrected. She was given the message that children do not cause addiction, and that it is not their behaviour, which causes a parent to use drugs. Brittany was reassured that even if she behaved in a way which upset her mother, she had many choices other then using drugs to handle the situation. Brittany was reminded that no one is responsible for the addict's actions, except the addict him/herself, and that children's actions cannot cause addiction.

Janie the puppet was used to help clarify and discuss these issues. Janie expressed feeling guilty about contributing to her own mother's drug abuse and asked Brittany how she felt. Brittany validated Janie's feelings by stating that she felt the same way. She then was able to clarify for Janie, that her mother's problems were not her fault, thus demonstrating that she had internalized the information and concepts presented to her. Janie came back in subsequent sessions to ask Brittany questions or seek out her support. This activity seemed to empower Brittany, by allowing her to help Janie and communicate her knowledge about addiction issues.

Given Nora's ongoing drug use and associated instability, Brittany presented with significant anxiety around her future and whether her mother would achieve

sobriety and reclaim her status as a parent. Thus, a primary focus of therapy involved helping Brittany to enhance her coping skills. To this end, Brittany and I explored her worries and fears and discussed different strategies for coping with stress. Brittany had already developed a repertoire of coping skills over the years. For example, she made up songs or listened to music when feeling sad and sometimes she wrote stories. To add to her skill set, I taught Brittany relaxation exercises and we brainstormed different things she could do when feeling anxious or upset. To ensure that these new skills would be utilized outside of the therapy context, Brittany made an *anti-stress kit* (Lowenstein, 2002), which included these ideas for relaxing and improving her mood. Another strategy we explored was "self talk" and she came up with a list of positive statements and messages such as, "I am a good person no matter what my mom does," to draw upon when feeling anxious or sad. By the end of the twelfth session, Brittany had developed a repertoire of coping skills and strategies that she could use in the future.

As therapy progressed, and with Nora's whereabouts still unknown, Brittany began to face the reality that her mother may never be able to resume parenting of her. It seemed as though Brittany had entered into a grief process, similar to the grief processes other people experience when they lose a loved one due to death. Unfortunately, for Brittany, and other children who grow up with an addicted parent, this grief process is much slower; it occurs over a much longer time and is much more subtle than the grief experienced due to losing someone through death (Black, 1982). An activity used to help Brittany heal her grief was letter writing. With my support, Brittany wrote a letter to her mom over the course of two sessions. This letter detailed

Brittany's feelings towards her mother, the impact that her behaviour has had on her, and her hopes and dreams for her mother and for herself. This activity was quite powerful for Brittany as evidenced by her release of emotions through crying.

In order for Brittany to work through her grief and face the reality that she may never be reunited with her mother, she needed reassurance that her Aunt would always be there to take care of her. This was important for Brittany, as she had been hesitant to attach to her Aunt out of fear that doing so would be disloyal to her mother. Brittany's feelings around this issue were explored, and she was encouraged to consider the positive aspects of living with her Aunt. The story *Little Miss Spider* (Kirk, 1999) was used to illustrate to Brittany that although her Aunt was not her real mother, she was someone who loved her and who would always be there to care for her. To further facilitate this process, the Aunt was invited into a session with Brittany and she was able to give Brittany the message that she was her family and as such would care for her permanently if need be.

All of the therapy sessions focused on helping Brittany to enhance her self-esteem. Opportunities to praise and compliment Brittany were incorporated into the overall structure of each session. For example, at the start of each session, I complimented Brittany on an aspect of her personality, and at the end of each session, Brittany wrote one positive attribute about herself in the petal of the flower. As mentioned, this flower also helped Brittany prepare for termination of the therapy process. Given that so many events in Brittany's life had been out of her control, it was important that she could predict and plan for termination. In our last session together, we reviewed all of our sessions and highlighted her accomplishments.

Brittany was given the flower to take home and a CD with Mariah Carey's song "Hero" as a reminder of her inner strength and resilience.

Brittany's treatment also consisted of meetings with her Aunt. These meetings provided an opportunity for me to share my impressions of Brittany and her needs and to make recommendations for parenting her. For example, I discussed with the Aunt how Brittany had become overly responsible in an effort to control her environment. I suggested to her that she could help Brittany achieve a better sense of balance in her life by discouraging any attempts by Brittany to take on adult roles and responsibilities within the home, and to support her participation in fun activities appropriate for her age. The Aunt followed this guidance and was able to report problems and progress in regards to her efforts in subsequent meetings.

Overall, the Aunt appeared to be trying very hard to support Brittany. She demonstrated empathy for her and the capacity to be nurturing. Despite having feelings of anger towards Nora, the Aunt was able to understand the complex range of emotions that Brittany felt towards her mother and she was able to validate these feelings without projecting her own feelings onto Brittany. In summary, the goals of the sessions with the Aunt were to: (a) provide information and education on Brittany's behaviours and needs, (b) to inform the Aunt of new skills that Brittany was learning in the therapy context so that she could reinforce them in the home environment, (c) to offer support, guidance and suggestions to the Aunt with regards to parenting Brittany, and (d) to help the Aunt recognize and appreciate small gains and improvements in Brittany's behaviour.

Evaluation

On the CBCL Brittany's T scores pre- and post-test for Internalizing Problems dropped from 63 to 45, Externalizing Problems increased from 34 to 43, and Total Problem decreased from 64 to 54, as reported on Table 3. The decrease in the Total Problem score moved Brittany out of the clinically significant range, into the normal range, suggesting that the intervention may have had a positive influence on her (See Table 3).

Brittany's scores fit with my clinical observations of her. As mentioned previously, Brittany presented as a withdrawn child who was invested in pleasing others. As such, it is not surprising that her scores were clinically significant pre-test for Internalizing Problems, and very low and in the normal range for Externalizing Behaviours. It is not clear what factors accounted for the increase in Externalizing Problems post-test, however, it could be hypothesized that as Brittany became more adept at expressing her feelings and acknowledging the reality of her situation, it produced a change in her behaviour.

Overall, it cannot be determined whether the intervention alone contributed to the drop in the Total Problem score. This is because the CBCL is based on parental perceptions, and thus the scores are more representative of the parent's internal state than the child's. Given Brittany's family situation, her mother completed the pre-test and her Aunt completed the post-test. Thus, it is quite possible that the Externalizing scores were lower in the pre-test because Brittany's mother was not parenting her. Also, this means that all the results must be interpreted with caution.

Table 3

T - Scores for the Child Behaviour Checklist at Pre- and Post-Test

Child		Internalizing	Externalizing	Total Problem
Brittany	Pre-Test	63*	34	64**
	Post-Test	45	43	54

Note:

* Indicates a borderline, clinically significant score on the total problem scale (between 60 – 63)

** Indicates a clinically significant score on the total problem scale (above 63)

Brittany demonstrated through her scores on the PHCSCS that she is a child with a good self-concept. All of her scores increased from pre-test to post-test (See Table 4). Brittany's Total Score pre-test was in the average range at 56, and at post-test, her score increased to 62, suggesting that the intervention may have been correlated with an increase in positive feelings about herself. There were no concerns noted on either the Inconsistency Index or the Response Bias Index.

The cluster scores fluctuated little from pre-test to post-test. T-scores of 50 and 52 respectively on the Intellectual and School Status cluster scale indicated a healthy self-perception of her ability to perform intellectual and academic tasks. Regarding the Physical Appearance and Attributes scale, her t-scores were 69 and 60 respectively, indicating a positive attitude about her physical characteristics. Her t-scores were 47 on the Anxiety cluster scale at both pre-and post-tests. This was in the normal range. Brittany's t-scores decreased from 55 to 47 in the Popularity cluster scale, which reflects her perception of her popularity with peers and ability to make friends. Although Brittany's post-test score for this cluster scale remained in the normal range, it may have decreased in response to expressed anxiety about the possibility of having to go to a new school in the fall. In the Happiness and Satisfaction cluster scales, her t-scores were 63 both times, the highest possible score, thus indicating Brittany had a strong feelings of being a happy person and easy to get along with. The most significant change between pre-and post-test, was within the Behavior cluster scale. The t-scores were 71 and 46 respectively, and both were in the normal range. The meaning of these scores wasn't clear, yet, it could be hypothesized

Table 4

T – Scores for the Piers – Harris Children's Self Concept Scale Pre- and Post-Test

Child		I	II	III	IV	V	VI	Total
Brittany	Pre-Test	50	69	47	55	63	71	56
	Post-Test	52	60	47	47	63	46	62

Note: Cluster Headings: I = Behaviour; II = Intellectual + School States; III = Physical appearance and attributes; IV = Anxiety; V = Popularity; and, VI = Happiness & Satisfaction

* Indicates a clinically significant score on the Total Problem Scale (below 44)

that the pre-test score was an attempt to deny the issues, while at post-test, Brittany began to acknowledge her problems.

My observations of Brittany were only partially consistent with her scores on this measurement. It was evident that Brittany embodied many resiliency traits and she was living with an Aunt who was very nurturing and supportive towards her. Thus, it seems logical that some of her feelings about herself would be positive, and therefore considered "average" as per the PHCSCS. I would have expected some of her scores to be a bit lower, particularly for the Anxiety and Happiness and Satisfaction Scales given the internalizing problems she was demonstrating. I also anticipated that Brittany would have given socially desirable responses, however, this was not the case as indicated by the Inconsistency and Response Bias Indexes.

On the client satisfaction form that Brittany filled out after the therapy and through an interview, Brittany indicated that she felt it had been a good experience. She recognized that she made significant progress with respect to being able to talk about her feelings and she said that she felt good about the entire process. She stated that she felt nervous before coming and felt better now at the end of the sessions. Brittany said she liked playing games and she particularly enjoyed it when Janie the Puppet popped in during the sessions. Brittany could not identify anything about the therapy process that she did not like. She said she would recommend it to her friends, but only if they had problems.

Conclusion

Brittany completed twelve sessions of therapy and to a large extent each of the goals were achieved. The most significant improvement for Brittany was her ability to

identify and express her feelings. Initially when Brittany started therapy she was emotionally constricted and somewhat in denial about her mother's drug use and how it was affecting her. At the point of termination, Brittany demonstrated the ability to express a range of emotion, both positive and negative about her mother. She recognized that she had a right to these feelings and that communicating them in appropriate ways was acceptable and not disloyal to her mother. At minimum, therapy offered Brittany a safe environment and supportive relationship in which to explore her emotions and behaviours that developed in response to her mother's drug use and abandonment. This was the first opportunity that Brittany had to break the secret of her mother's drug use. Hopefully, the positive experience in therapy will serve her well in the future if she decides to choose therapy for herself.

At the point of termination, Brittany's future was still uncertain given her mother's relapse. Child and Family Services had been granted a six-month order of guardianship on Brittany and her brother, with a view that the children would only be reunified if Nora completed long-term residential treatment. It was suggested to the Child and Family Services social worker that Brittany might benefit from therapy again in the future, if new concerns arise for her as she approaches different developmental stages. Additionally, I suggested that because Brittany had broken her silence regarding her mother's substance use in individual therapy, she might benefit from participation in a group with other children who share similar concerns. Coincidentally, a group for children coping with parental substance abuse was starting in the community and it is my understanding that the social worker referred Brittany and that she completed the group. In this way, the individual therapy served as a

foundation for Brittany to progress to a therapeutic group where she was able to connect with other children and have her experience of parental drug use normalized and validated by them. This is an aspect of therapy that the individual work could not offer to Brittany. This supports the literature which advocates for the use of an interdisciplinary, systemic treatment approach that involves various modalities of counselling, as well as a combination of other interventions as part of the child's treatment plan (Lowenstein, 1999).

The Case of Sam

Presenting Problem

Bea, a single parent to four children, contacted the Elizabeth Hill Counselling Centre, at the insistence of a school teacher, to request counselling for her eleven-year-old son, Sam. The teacher was concerned because Sam bullied other children, had frequent outbursts of anger, and was verbally abusive to his teachers. Bea shared the teacher's concern about Sam and noted that he was also physically aggressive and verbally abusive to his three younger sisters as well as to her. Bea was feeling overwhelmed in her attempts to parent Sam and manage his behaviour which was resulting in frequent school suspension and conflict at home.

Sam's parents divorced when he was eight years old, with Bea assuming sole custody of the children. Sam's father had been violent towards Bea during their ten-year marriage. Bea described this period of her life as chaotic and crisis oriented. She was trapped by a distressing and intimidating web of events within the home including drug abuse and drug dealing, forced sexual acts and sexually degrading behaviours,

threats of violence, and physical assault. Bea was a victim of severe abuse by Sam's father, whose behaviour was further impaired by his addiction to alcohol and drugs.

According to Bea, Sam was not physically or sexually abused by his father. In fact, Sam's father tended to favour him over his sisters, and spent a lot of time with Sam in sports related activities. Sam was a very good hockey player, and his dad often attended his games. Sam did however witness his father's violence towards his mother and on occasion he got caught in the crossfire. For example, when Sam was four years old, he was hit in the head by a shoe and needed to get three stitches. During another incident, Bea and her husband were pulling on Sam's arms, each trying to take him away. Sam also experienced a one-month placement in foster care, the disruption of moving to a shelter, being separated from his father, being interviewed during divorce proceedings, and relocating to a new home. Six months prior to the referral, Sam had had his first visit with his father, and was continuing to visit him on a weekly basis. The father had just applied for sole custody of Sam and the matter was before the courts and unresolved at the point of referral.

Bea sought treatment for Sam upon the recommendation of the school system, but also because she recognized that her son needed help. Sam, once a top student, was behaving violently at home and at school. Bea reported that Sam hit, kicked and choked his younger sister; in addition, his mother described "tantrums" in which Sam directly attacked her and screamed obscene names. Sam had also withdrawn from friends at school and had gained a reputation as a bully. According to Bea, Sam had presented with aggressive behaviour since he was two years old, however she indicated that it had gotten progressively worse over the years. Professional treatment

for Sam was considered earlier, but not followed through on until his behaviour became more violent and unmanageable.

Bea suspected that Sam's shift in behaviour was associated with his visitation with his father. She also recognized that Sam's aggressive behaviours provoked memories in her of the abuse in her marriage and in her childhood. Bea's confidence as a parent was shaken. She feared losing control, and felt vulnerable, scared, and helpless. At the same time, Bea identified herself as a survivor and was committed to helping her son work through his behavioural problems in therapy.

Preliminary Assessment

Sam had been a young witness to parental violence and chaotic events over which he had exercised no control. Silvern and Kaersvang (1989) write that "witnessing parental abuse entails the fear, helplessness, and overstimulation that are the crux of trauma" (p. 423). These traumatic experiences occurred from the time Sam was an infant until his parent's separated when was eight years old. During these various stages of development, Sam was learning about male-female relationships, and internalizing parental identifications. Sam had also been exposed to other cumulative risk factors such as custody conflict, limited parenting skills, parental drug addiction, and poverty. Sam's behaviour therefore had multiple determinants.

Sam must also have possessed some inner strengths to have survived the stressful events that followed the aftermath of parental violence including his flight from home; the long separation from his father; invasive court experiences; and relocation to a new home and school. His mother's capacity to safeguard herself and her children likely provided a certain degree of stability as well.

It was clear that Sam was a very angry and confused child. He was doing well in sports, but at school he was getting into increasing difficulty with his behaviour. He got into several fights with other boys, and his attitude towards teachers was very disrespectful, especially towards his female homeroom teacher. Sam's grades had dropped and he was placed in a specialized classroom for children with learning and behavioural problems. He had difficulty talking about his feelings about the violence and the divorce, but stated a firm wish to live with his father. He indicated that his father and he had more interests in common than he and his mother. While Sam was clear that he wanted to live with his dad, he was also clear that he did not like it when his father encouraged him to make false disclosures of abuse against his mother. Consequently, in an attempt to resolve these feelings, Sam felt the need to choose between loyalty to his father against his mother, and loyalty to his mother against his father.

The family context of the presenting problems was also important. Sam's mother was a victim too, and Sam's aggressive behaviour at home mirrored her ex-husband's abuse. Bea was finding it difficult to remain empathetic when her son's behaviour was such a strong reminder of her own victimization. She tended to respond to Sam's behaviour with yelling and name-calling. Sam in turn, thought of himself as the "bad one" and proved it by fighting with everyone in his family. His negative self-concept however probably predated his current acting out and reflected the blame he cast upon himself for the parental violence he witnessed and for his parent's divorce. Given these dynamics, Sam was in a crisis state, and his behaviours signalled a need for immediate help.

Treatment Plan

The treatment plan was to see Sam weekly for individual sessions using directive play therapy, and also to meet weekly with Sam's mother. Conjoint crisis intervention sessions involving both Sam and his mother were planned as necessary, as were contacts with the Child and Family Services social worker. The child welfare agency had become involved to investigate allegations of abuse and neglect made by each parent against the other. The allegations were not substantiated, but the agency was maintaining involvement to monitor the situation and ensure that Sam and his siblings were getting their needs met. Bea would not consent to my having contact with Sam's school, even though I thought it would be in Sam's best interests. Her reasons for this were not clear.

Treatment planning was complicated. The need for multiple treatments-individual, conjoint, and family-were beyond the scope of this practicum; yet the crisis nature of the case required intensive collateral sessions with Sam's mother to stabilize the family system. Although this approach risked compromising Sam's independent claim on me as *his* therapist, I felt that Sam's interests were best served by bolstering his mother's functioning when crises arose.

Goals

The primary goal was for Sam to develop a nurturing relationship with a therapist (myself) who could model empathic and controlled behaviours. It was hoped that the therapeutic relationship we established-in contrast to other adult relationships in his life-would be reparative and help to modify his expectations of rejection and retaliation.

Additional goals of treatment were to (a) help Sam express, clarify, and label feelings related to the violence he witnessed and separation of his parents, (b) to teach Sam anger management and coping skills, (c) to coach Sam in socially approved ways to cope with his sense of anger towards his mother, (d) to clear up any cognitive distortions that Sam had in relation to his experiences with parental violence, divorce and sex and gender roles.

An important part of Sam's treatment was to work intensively with his mother. Specific treatment objectives were 1) to help Bea become aware of her own conflicts and their displacement onto Sam, 2) to increase Bea's ability to set limits in nonpunitive ways that did not enact anger, 3) to help Bea improve her understanding of Sam's feelings and needs rather than project her own, and 4) to assist Sam and his mother in learning concrete ways to deescalate conflict as it emerged between them.

From a person in context perspective, collateral and conjoint interventions to modify Sam's home environment were deemed necessary to secure whatever gains Sam made in his individual sessions.

Therapy Format

The first three sessions focussed on assessment, with a view of being able to obtain a richer understanding of Sam's emotional and behavioural functioning. When Sam demonstrated that he was feeling safe and comfortable in the therapy context, content related to the identified goals was introduced into the sessions.

The play sessions were primarily directive in nature with the first fifteen minutes devoted to check in, snack and engagement activities. The next thirty-five minutes focused on structured therapeutic activities based on the above stated goals,

and the final ten minutes of each session were devoted to session review and free playtime.

Therapy Process

The early work with Sam involved developing the treatment relationship. Initially, Sam was a reluctant participant in therapy. He was angry with his mother for making him come and he was clear that he would rather be at home playing video games. Theraplay activities were used to engage Sam and he responded favourably once he learned that fun and games were going to be incorporated into each session. Sam participated fully in these games and he seemed to particularly enjoy those which required athletic ability and skill. By session three, Sam appeared relaxed and engaged in the process. He had familiarized himself with the structure of the sessions and seemed content with the format, although he often wanted to rush through the activity related to a theme and get to the free play. From a developmental perspective, this was probably normal, although it may have also reflected some avoidance on his part.

A number of directive tasks were introduced to Sam in the sessions, which often provided a foundation for less structured discussion. For example, in the first session, Sam agreed to draw a picture of his family from which an initial discussion of family relationships ensued. Sam drew a picture of his mom and sisters on one side of the page and then flipped it over and drew a picture of his father on the other side. When asked why he didn't draw himself anywhere in the picture, Sam said he forgot. I asked if he would like to draw himself into the picture and he said, "no, there is no room for me." This assessment activity seemed to reflect Sam's confusion about

where he belongs in his family and highlighted his feelings of divided loyalty. It also led to further discussions around different types of families, including divorced families, which in turn normalized Sam's own family situation.

Early work with Sam also involved feelings identification and expression. Several activities were introduced as a means of helping Sam to identify and express his feelings, first generally, and then later more specifically as they related to his family. Over the course of therapy, Sam developed an extensive feeling vocabulary. During each check in, Sam was asked to identify how he was feeling and then to draw it on paper. During the first few sessions, Sam referred to the feeling faces poster to define his feelings. He often reported feeling "happy" and drew a smiling face to illustrate this. In subsequent sessions, Sam referred to the poster without prompting and noted the presence of more complex feelings. For example, in session three, Sam reported that he had been suspended from school and was feeling angry and sad about it. He drew a picture of a face, and then made half of the face sad and the other half angry. Sam began to internalize a feeling vocabulary and became increasingly comfortable expressing his feelings verbally, and symbolically using arts and crafts and physically through his actions. Sam was particularly fond of playing *Feelings Basketball* (Lowenstein, 1999), and he even requested to play it during free time. In this specific game, Sam and I took turns shooting baskets. If we were successful at getting a basket, we would pick a card from the "happy face" pile. If we missed, we chose a card from the "sad face" pile. The cards all had questions pertaining to happy and sad experiences in a person's life. For example, "What is your biggest worry?" As Sam responded to the questions, I was able to reflect his feelings and, when

appropriate, I asked him to elaborate. When I answered questions I was able to model and encourage open disclosure, and draw Sam closer to specific treatment issues. Further work on identifying and expressing emotions was incorporated into all twelve sessions.

As Sam became more adept at communicating his feelings, therapy began to focus more specifically on assisting him to recognize his signs of anger and develop better ways to cope and express it. Various media were used to facilitate this process, including an anger workbook, drawings, relaxation and de-escalation techniques, as well as scaling. During one session, Sam and I made a volcano, and we added ingredients to make it erupt. The volcano was then used as a visual metaphor to discuss what happens when we stuff our feelings. In another session, I drew an anger meter and invited Sam to detail the level of anger he felt towards individuals on a scale of zero to ten, with the latter representing the angriest. He indicated that his anger towards his mother was the strongest at "ten" and his father, was scaled at "seven." This exercise was useful for a number of reasons. First, it reflected Sam's feelings back to him in a visual manner in order to foster a new understanding of his relationships and emotions. Secondly, it enriched the assessment. By providing more detailed information about Sam's relationships with his family members, I was able to recognize varying degrees of conflict between himself and members of his family.

Throughout the course of therapy, Sam was encouraged to practice newly learned skills outside the therapy session. His mother was briefed on the strategies that Sam was learning so that she could coach him between sessions. During one session, Sam reported that he had gotten suspended from school for swearing at his

teacher. He said that he was upset that he had not utilized his new skills and wished he could start his day over again. Building on this theme, I asked Sam to engage in some imaginary play. Accordingly, he stepped into a time machine, which took him back to the beginning of the day. He proceeded to act out his morning at school but instead of swearing at his teacher, he used his newly acquired anger management skills and thus avoided suspension. Sam loved this activity, as evidenced by his dramatic antics. This activity demonstrated how directive therapy can strategically incorporate external reality into a play scenario to engage a child and enhance his competency. In addition, the time machine exercise was not something that had been planned, thereby showing the importance of allowing for flexibility within structured sessions.

As Sam moved to a more engaged and ready state, directive activities and related discussions were incorporated into the therapy sessions to address deeper issues pertaining to violence, divorce, feelings of blame and responsibility, divided loyalty, as well as sex and gender roles. These activities helped Sam to express his thoughts, beliefs and emotions, and as the therapist, I was able to validate his experiences and correct any cognitive distortions. During one session, Sam was asked to draw a picture of fighting in his family. He drew a detailed picture of his father strangling his mother on the staircase. Sam recalled that he was three years old when this incident occurred and he remembered feeling scared and sad. The story *Mommy and Daddy are Fighting* (Paris & Labinski, 1986) was also read to Sam and a game which focused on family violence myths was played. Both of these activities highlighted the fact that Sam was holding his mother accountable for her own

victimization. Through discussion, Sam's internalized beliefs were challenged and corrected.

This same process occurred around discussions of divorce. Sam drew a picture to symbolize his feelings of being "caught in the middle" and he also made a list of things that he finds confusing in his family. This exercise presented a nonthreatening way for Sam to ask questions and create a dialogue about his feelings. Overall, these activities helped Sam to learn about the violence that he witnessed and his parents' divorce. He was given consistent messages that he did not cause the violence or the divorce, that he could not have prevented either from happening, and that it was okay to feel sad and angry about his experiences.

During the course of treatment, the post-divorce conflict between Sam's parents increased. The impact of this on Sam was evident during sessions. He often reported feeling angry towards his mother and he was adamant that he wanted to live with his father. Sam described his father as fun and said that he spent more quality time with him than his mother. Many sessions focussed on providing a safe place for Sam to vent his frustrations and anger over his parent's divorce and the custody battle. Sam was given the message that while he was unable to control the behaviour of his parents or the outcome of the custody case, he was able to control his own behaviour. We explored self-talk as a technique for reducing worry and anxiety as well as other coping strategies and we also examined areas in Sam's life where he does have control.

An important part of the entire counselling process was the therapeutic relationship. As such, I attempted to provide support and nurturance to Sam while

emphasizing his uniqueness and bolstering his self-esteem. Sam related well to me throughout therapy and he responded positively to praise and compliments. By emphasizing his strengths and accomplishments through validating remarks, I encouraged Sam's self-confidence in his ability to achieve. Sam was therefore able to experience that intimacy does not need to involve threat (Gil, 1991) and that despite knowing about the traumatic stressors in his life, I would continue to care about him (James, 1989). My role as a non-judgemental person who listened was an important objective for a child whose emotional needs were often overshadowed by other parental and family concerns.

A final level of intervention was directed toward Sam's mother. My approach was to enlist her as a partner in Sam's treatment. Bea was receptive to such an approach, however, she was prone to stress and crisis. This fact complicated her ability to engage fully in a working alliance with me. She found it difficult to focus on Sam because her own personal needs were so overwhelming. I learned through discussion that Bea was a trauma victim both as a child and an adult, and it was my impression that her intense reactivity to Sam's behaviour, difficulty in regulating emotion, and chronic experience of stress were symptoms of these experiences. Sam's aggression at home sparked her conflicts about men and made her feel victimized once more. In fact, Bea even commented that Sam once "gave her a look," that reminded her of his father, and it triggered uncomfortable feelings in her.

In general, Bea was having difficulty controlling her anger and she also struggled to manage Sam's behaviour. As a result, verbal and sometimes physical fights occurred at home between mother and son. Bea wanted complete separation

from Sam's father, but Sam yearned for contact, a wish appropriate to his preadolescent stage of development (Jaffe & Sudermann, 1995). Sam's wish for his father was in contrast, however, to Bea's need for emotional safety. Bea also feared losing Sam if he decided at some future point to live with his father. My sessions with Bea therefore were integral to the overall treatment plan. Bea needed to understand why her son was the focal point of her rage, and how her own trauma contributed to the family dynamics. In addition, Bea needed to learn behaviour management strategies, and learn to recognize her own warning signs of anger. Furthermore, Bea needed to develop a plan to recognize and respond to escalating conflict between her and Sam. Over the course of Sam's therapy, these identified issues were discussed and addressed.

Evaluation

On the CBCL, Sam's pre-test score for Internalizing Problems was 54, which is in the average range; and his Externalizing Problem score was 75, which is considered clinically significant. His Total Problem scale score at pre-test was 68, which placed him in the clinically significant range (See Table 5). These scores are consistent with my observations of Sam who presented with acting out behaviours at the start of therapy. Additionally, because the CBCL is a measure taken from the parent's perspective, Sam's scores were indicative of how his parent perceived his behaviour. It was quite evident that Bea was overwhelmed in her role as a parent, and therefore it is not surprising that Sam's scores were clinically significant. Bea and I had an appointment to complete the post-test CBCL together, however she

Table 5

T – Scores for the Child Behaviour Checklist at Pre- and Post-Test

Child		Internalizing	Externalizing	Total Problem
Sam	Pre-Test	54	75	68**
	Post-Test	N/A	N/A	N/A

Note:

* Indicates a borderline, clinically significant score on the total problem scale (between 60 – 63)

** Indicates a clinically significant score on the total problem scale (above 63)

cancelled this meeting. I was not successful in connecting with Bea to reschedule this meeting, and therefore a comparison of pre- and post-test scores was not possible. In retrospect, knowing that Bea lived in a chronic state of crisis, I should have completed the CBCL with her long before Sam's therapy ended.

The PHCSCS indicated that Sam's self-concept varied little over the course of intervention and generally indicated a healthy level of self-esteem (See Table 6). His Total Score remained constant at 56 from pre- to post-test. In the pre-test, all scores were in the normal range, although the cluster scale t-score of 42 for Intellectual and School Status was in the borderline range. Nevertheless, the score did represent a satisfactory self-perception of his abilities with respect to intellectual tasks, including general satisfaction with school.

Sam's pre-test and post-test scores varied little. The cluster scale t-scores changed in the following manner during the course of intervention. Behavior t-scores changed from 54 to 59, the pre-test score of 42 for Intellectual and School status increased to 48, t-scores for Physical Appearance and Attributes changed from 53 to 64, cluster scale t-scores for Anxiety decreased from 69 to 59, Popularity t-scores increased from 51 to 61, and Happiness and Satisfaction t-scores increased slightly from 56 to 63. Thus, Sam's perception of his own behavioural problems varied little, in that a high score indicates either denial or lack of behavioural issues. Sam's attitudes about his appearance and attributes as a leader and his ability to express ideas strengthened. These high scores are not surprisingly given that Sam was an attractive boy, and told this regularly by his mother and likely others as well. It is not clear what

Table 6

T – Scores for the Piers – Harris Children's Self Concept Scale Pre- and Post-Test

Child		I	II	III	IV	V	VI	Total
Sam	Pre-Test	54	42	53	69	51	56	56
	Post-Test	59	48	64	59	61	63	56

Note: Cluster Headings: I = Behaviour; II = Intellectual + School States; III = Physical appearance and attributes; IV = Anxiety; V = Popularity; and, VI = Happiness & Satisfaction

* Indicates a clinically significant score on the Total Problem Scale (below 44)

the change in the Anxiety cluster scores indicated, although they remained high, and therefore did not point to emotional disturbance. The t-scores for the Popularity cluster scale climbed from 51 to 69, suggesting that Sam had developed a more favourable self-perception of his ability to make friends and general popularity among his classmates. This may have been related to the positive changes in his behaviour. Lastly, Sam's scores for the cluster scale, Happiness and Satisfaction, increased to 63, the highest possible number, suggesting that Sam had a general feeling of being a happy person. This score was a bit surprising given that Sam's multi-problem family situation had changed little over the course of the intervention. It could be hypothesized however, that although his family situation did not change, Sam was coping better at post-test.

Sam expressed during the post intervention interview that he had liked coming to therapy. He stated that he enjoyed *Feelings Basketball* (Lowenstein, 1999) the best and would miss playing games with me. He said that he liked "talking" the least, but "sometimes, it was okay." Sam said he would recommend therapy to all of his friends, in particular to his friend Steven who was "acting up" at school.

At termination, Bea was somewhat distressed. She expressed that getting new ideas and having my support were very helpful to her. She acknowledged that Sam's behaviour had improved, however she was worried that without ongoing therapy his behavioural changes would be short lived. Bea advocated for therapy to continue, however this was not possible given the time restraints of the practicum, and also because it was felt that Sam needed time outside of the therapy context to practice his skills. Instead, it was recommended to Bea that she continue on with therapy for

herself. With her agreement, a referral was facilitated for individual therapy with one of the full time clinicians at EHCC. It is my understanding that Bea attended for one session, and then did not return.

Conclusion

Sam was attempting to deal with the onset of adolescence within a multi-problem family. He was engaging in the regular developmental concerns involving self-identity within an environment that had demonstrated the devaluation of women, the use of interpersonal aggression to release anger and resolve conflict, and the application of unhealthy coping skills, such as bullying. Although adolescence involves a move away from family towards peers, adolescents also need parents to model how responsible adults get their own needs met (Jaffe et al., 1990). Despite his growing independence, Sam required the guidance of his parents as role models in order to develop a corpus of values and skills so as to interact effectively in the adult world. Unfortunately, Sam's parents were struggling with their own personal needs, and therefore limited in their ability to help their son.

A directive play therapy approach was chosen to engage Sam in a nonthreatening, empathic way. In the context of the ongoing custody battle between his parents, the treatment relationship itself was viewed as a reparative intervention. Sam did engage well and participated in play activities that revealed a sense of powerlessness, feelings of divided loyalty, loss and anger. A directive approach was particularly appropriate for Sam as it allowed traumatic events to surface and be addressed in the context of safety and support. Beverly James (1989) supports using an active approach involving guided play and direct discussion of events for

traumatized children who "cannot initiate discussions of matters that overwhelm them" (p. 11).

Over the course of the therapeutic process, Bea became slightly more emotionally available to her son. She slowly started to move away from pathologizing Sam and began to empathize with his confusion around separation and divorce.

In summary, it would seem that treatment had provided some gains for Sam and his mother. Bea reported that Sam's behaviours at home and at school had improved, with less aggression and no suspensions. The intensity of conflict between Sam and his mother decreased, and the level of initial anxiety dissipated. The treatment process created an opportunity for Sam to experience an empathic relationship with an adult. Within the safety of the therapy context, he could express feelings about his parents, both positive and negative, that otherwise would not have been allowed within his home. This allowed some ventilation of his anger, disappointment, and sadness. Knowing that he could be understood without retaliation helped to allay his crisis state. His positive experiences in therapy would hopefully serve as a foundation for treatment at some later date, when Sam might be in a position to choose therapy for himself.

From a personal perspective, I started therapy with Sam with the hope of being able to make significant changes in his life. However, as the therapy process progressed, the task of helping Sam seemed overwhelming given the nature and extent of his familial problems, e.g., the custody/access battle, the father's lack of commitment to participate in therapy, the mother's own personal needs etc. I therefore questioned my role and ability to have a positive influence on Sam and his behaviour.

In retrospect however, I realize that while I could not change events in Sam's environment, or change his future life course, I was able to offer him a "time out," a safe place where he could experience unconditional positive regard, share his feelings, and have them validated. Thus, I learned through this experience, the value of the therapeutic relationship for children. In and of itself, the relationship that forms can be powerful for children and should not be underestimated.

CHAPTER SIX-PRACTICE AND LEARNING THEMES

The assessment and intervention for this practicum concentrated on children who had been exposed to parental violence. The purpose of this chapter is to discuss the common practice themes that emerged through the work with the children in this practicum. Group work as an intervention modality will be compared to individual therapy, the importance of working systemically with children will be discussed as well as the use of play in therapy. It is hoped that an understanding of these common themes will help create models for practice with children who have been exposed to parental violence.

Individual Therapy versus Group Work

In the literature, there is a strong bias towards the use of group therapy with children who have been exposed to violence (Jaffe et al., 1990; Peled & Davis, 1995). Primarily, this is because group therapy relies on group process to target the feelings of isolation and stigmatization experienced by many children who have been exposed to parental violence (Jaffe et al., 1990; Peled & Davis, 1995). Individual therapy is only recommended for children whose behaviours and problems are so severe that they could not be managed within a group setting (Arroyo & Eth, 1995; Jaffe et al., 1990; Silvern et al., 1995). While the above represents the ideal, as I learned through this practicum experience, counselling agencies such as the EHCC do not always have the luxury of matching children with the appropriate intervention and subsequently there are times when the chosen intervention for a child is based on funding, staffing, and/or what service is available at the time. Obviously, individual therapy requires only one staff person and is likely more cost efficient than a group, thus making it

more of a viable option than group work. Through this practicum, I was fortunate to have a varied experience by working with a group, with individual children, and with their parents/caregivers. While the group intervention did offer a benefit to the children, the individual work was perceived to be beneficial as well, leading me to agree with Jaffe et al.'s (1990) conclusion that children who have been exposed to violence "are almost universal in their need to be listened to, believed and supported. They usually are not looking for solutions but an opportunity to share their fears about their mother and perhaps all members of their family" (p. 83). Both individual and group work can create an environment for children to heal in this way, and thus, both interventions should be considered for children who have been exposed to parental violence. A comparison of the two interventions follows.

The group intervention involved a multifamily component, which gave me the unique opportunity to observe the children in interactions with their mothers. In addition, through supervision, I was able to meet with the two leaders from the mother's group. This was very helpful in that I was able to get information on how the mothers were coping, which in turn enriched my understanding of the children in the group and their behaviours. In working with individual children I was able to intervene in a much more personalized way with the children I saw, giving each child my complete and undivided attention. There was also an opportunity to work more intensely with each of their caregivers on their specific issues.

In comparing the group intervention and working individually with children, there were similarities and differences. In the group, many issues could be discussed in a teaching format, for the purpose of discussion, for all the children to hear. Even if

one of the children did not openly say anything, they were still listening and processing what other children were saying and feeling. This exposed them to a number of reactions and realities. As the group leader, I could utilize one child's situation as a general metaphor for the whole group. With individual children there was not the same opportunity to provide this type of metaphor with other children, although it was achieved through puppets and the play situations. The focus and intervention was also different. There is a certain energy and commonality that is present in a group, that is not present when children are seen individually. On the other hand, I did not have the time to really listen to each child in the group as much as I would have liked or they would have liked. This came through in the client satisfaction form as well. Some of the children said they would have liked more time to tell their story and to be really heard by the leaders.

Individual work allowed for total attention to be paid to the child with no competition from the other children. I could focus, not only my attention, but also the play, specifically to that individual child. For example, parental substance use was the focus of my work with Brittany, with exposure to violence being somewhat of a secondary issue. I was able to be creative in planning activities for her and I was able to use flexibility when required. The relationship and level of trust that I developed with each child was more intense because of this. In the group, my focus was often on managing the behaviours of the children, thus making it difficult to observe the more subtle interactions and dynamics between the children as well as to hear individual comments. Both intervention formats have their strengths and I am very grateful to have had the experience of doing both. Whether one intervention or the other had

more success would be impossible to comment on, as their circumstances were very different.

Systemic Intervention

Many children in treatment present with a multitude of problems, and therefore require a comprehensive and multi-faceted treatment approach. Individual, group, or family counselling may form part of the child's treatment plan and additional interventions may be needed to address the child's issues. Therefore, an interdisciplinary, systemic treatment approach that may involve various modalities of counselling, as well as a combination of other interventions is recommended in the literature for children exposed to violence (James, 1989; Lowenstein, 1999, 2001). In accordance with this, the mothers of the children involved in the group intervention participated in a parallel group and a multi-family group. For the children who participated in individual therapy, their parents were involved as part of the entire process and met with me as required. Additionally, attempts were made to integrate the child's treatment plan into an overall community response by mental health, social service, and legal professionals.

Parent Counselling

Whoever provides the child with primary parenting care must become involved in the treatment process if the therapy is to be effective (James, 1989). Lieberman (1979) maintains that "unless parents collaborate in treatment, little can be done to help the child." (p. 225). Arnold (1978) clarifies that "it is the parent's relationship with the child that is essential for the child's mental health, not the professional's relationship with the child." (p. 12). Further, Arnold (1978) states that "an effective

parent is the child's most important therapist" (p. 6). Conveying to a parent that they will serve as an essential ally of the therapist forms the basis for the therapist-parent alliance. Many therapists who work with children keep this alliance vital by meeting with parents on a regular basis to discuss their children's behaviour and reactions, while also establishing a telephone policy inviting parents to notify them of any matters of concern about the children (Boyd-Webb, 1999; James, 1989). A therapist respects the confidentiality of the child client by refraining from reporting verbatim comments made by the child in treatment, and by discussing with the parent only general issues related to the child's treatment.

Throughout this practicum process, the parents were involved in their child's therapy. In the group intervention, the mothers participated in a parallel group and then simultaneously in the multifamily group. While I was not directly involved in facilitating these groups, I did maintain contact with the leaders of the mother's group, in order to share information and in recognition of the interrelated and reciprocal nature of the parent-child issues. In the individual work with children, the mothers were employed as partners in their children's therapy: for Brittany, whose mother was unavailable, it was her Aunt who was included in the process. As mentioned previously in this report, the Aunt was involved in a limited, yet consistent way. In contrast to this, Sam's mother maintained regular involvement with me; however, her overwhelming personal needs, at times compromised her ability to focus on her son's needs thus presenting a challenge to me as the therapist. The above examples, support the literature, which notes that non-offending mothers should secure safety for themselves and attend to basic needs prior to participating in child-centred counselling

(Bilinkoff, 1995; Rabenstein & Lehmann, 2000). With respect to Sam's situation, it should be noted that this ideal was acknowledged at the point of intake, but it was also recognized that Sam needed immediate intervention for his aggressive behaviour. It was hoped that individual therapy with Sam would also bring about changes in the family system, including parenting behaviour. This is consistent with the literature which suggests that providing therapy to children in a way so that the parents are fully involved in what is going on, and that they are given where necessary appropriate guidance and help, can be highly effective in helping both children and their parents with their difficulties (Wilson & Ryan, 2001).

Environmental Considerations

It became apparent when working with the children that many of their families were experiencing significant stress in their lives. This is consistent with the literature which discusses how parental violence is often accompanied by additional problems including stress from divorce, financial debt, unemployment, or homelessness (Jaffe et al., 1990). All of the families involved in this practicum were struggling with one, usually more, of these stresses simultaneously. It became apparent through both the group and individual interventions that if basic needs were not met for these families, it compromised their ability to focus on higher level goals related to the violence they had experienced. Therefore, the use of a systemic perspective was important in identifying these associated environmental stressors and addressing the range of needs that the children and their families presented with. This involved working collaboratively with external agencies involved with the families and ensuring they were supporting the families and working with them on complementary goals. For

example, two of the families that participated in the group intervention were intensively involved with Child and Family Services, and as the group evolved, further needs emerged that the group could not address. The sharing of information between organizations was helpful to coordinate and plan for post-group services within the community to ensure gains made in the group would be supported beyond the group's termination.

Using Directive Play Therapy with Children Exposed to Violence

Directive play therapy, whether utilized in a group or individual context can be a helpful modality for working with children exposed to violence. While non-directive play therapy methods have traditionally been utilized to assist children in processing unresolved conflict (Gil, 1991; James, 1989; Lowenstein, 1999), directive play therapy offers a concrete approach that facilitates open disclosure and guides children closer to specific treatment issues (James, 1989; Lowenstein, 1999, 2001). Bringing children's issues out in the open in a supportive but direct fashion lets them know that their problems are not shameful and can be discussed (James, 1989). Directive play therapy is goal oriented. The therapist structure each session according to what they believe will be beneficial in the treatment process. In doing so, the therapist is directing the session and the child is following his/her lead. This approach can be described as the therapist taking an active role in the therapeutic session as they decide the activities to play that would specifically focus on an issue of concern. For example, a child may be asked to draw a picture of fighting that he/she has witnessed in their family. Directive play therapy also encourages the child to take part in an interactive activity, which can help the child improve his/her social skills. This

modality allows the therapist to set the goals for the current session and for later sessions in the treatment process. By involving the therapist directly in the session, the child can feel less threatened to perform or express their emotions. This way the therapist normalizes the activity, which therefore encourages the child to engage in the activity.

Directive play therapy techniques were utilized throughout the practicum process in both the group and the individual interventions. The approach seemed well suited to the children who participated in this practicum, because they came to therapy with feelings of shame and anxiety as result of the violence they witnessed. The creative and imaginative use of structured activities, games, and exercises was a source of fun, play, and enjoyment for the children. Directive activities further served to engage the children as well as to capture and sustain their interest and motivation throughout the therapy process. Discussing difficult issues such as violence or parental substance abuse also became easier for the children when it was done in the context of play. For example, Brittany's feelings regarding her mother's drug use were very repressed when she started therapy. When Janie the puppet came to session, you could literally see a transformation in Brittany's entire presentation. Physically, Brittany moved closer to Janie and at one point she even touched her back in a supportive gesture. Brittany also demonstrated empathic listening as Janie told her story and Brittany was then able to discuss her own feelings. For Brittany and the other children, the directive activities utilized in this practicum seemed to appeal to them and contributed to a positive counselling experience.

The directive play therapy modality also appealed to me as a social worker providing therapy to a challenging population of children. Directive play therapy provided a structure and predictability that helped me to focus on the concrete issues, rather than in an environment where there was no planned activity between the therapist and child. In addition, directed play therapy allowed me to address the specific issues of the children in a timely manner and this aspect of therapy is important given the financial restraints of many agencies as well as the fact that many multi-problem families tend to drop out of therapy prior to all of the goals being achieved. I do recognize however that directive play also has its limitations. For example, many children would not respond well to such a structured environment and may benefit from a more non-directive approach. Accordingly, directive play therapy, while having many benefits, cannot be considered the optimal treatment modality for all children. For example, in the case of a child with a speech delay it would be difficult to use the directive approach since this child would struggle to comprehend what is being asked of them. A better approach might be to provide an environment where the child is free to explore and choose an activity or toy of his/her choice. Within this setting, the therapist would observe the child's actions and listen to the child rather than ask direct questions and give the child feedback. This approach is contrary to directive play therapy and illustrates that not all children can be treated by one modality. Instead, therapy needs to be prescriptive, and based on the specific needs of the child.

In summary, I have felt comfortable using directive play therapy with the children involved in the group and individual therapy because of the structure it

provides and also because I believe in its ability to engage children and address their issues in a nonthreatening manner. However, even though my confidence lies with a directive approach, I understand that in order to be a prescriptive play therapist, I would need to tailor my sessions according to what is an appropriate treatment for the specific child with whom I am working. Therefore, I may need to incorporate other interventions, including non-directive techniques into the overall treatment plan for the child.

CHAPTER SEVEN-CONCLUSION

Learning Objectives

A number of client-focused and personal objectives guided this practicum. Through the implementation of group and individual therapy with children exposed parental violence, I believe that I was able to achieve these objectives. In reflecting upon the practicum I was also able to identify several recommendations for future interventions with this population of children.

Client-focused objectives

As evidenced by the qualitative and quantitative evaluation methods, a number of client-focused objectives were accomplished. In particular, I was able to create a therapeutic environment that was safe, fun, and supportive, to help children express their feelings and experiences related to family violence, and enhance their self-esteem. In addition, the group and individual work provided an opportunity for the children to understand family violence so as to alleviate self-blame and attribute responsibility for the violence to its true source, develop non-violent conflict resolution skills and internalize a foundation of safety and coping skills to be used in relationships and in response to future stressors. The degree to which these objectives were met varied among the children, and was largely dependent upon a host of factors including the severity and extent of the violence witnessed by the child, the presence of other problems such as housing, substance abuse, or divorce, how resilient the child was, and most significantly, the availability and consistency of community and familial support to the child.

Personal Objectives

As my personal objectives were more controllable than those focused upon the children, the majority were achieved during the course of this practicum. In particular, I increased my knowledge about the impact of witnessing violence in the home for children. While I became familiar with externalizing and internalizing symptoms, behaviours, and attitudes among children in this population, I also learned that witnessing violence was not always the most pressing issue in the post-crisis and post-separation phase of these families. For instance, some children were affected by divorce and parental substance abuse. As a result, it was important to look beyond the violence to consider these other factors. In fact, it was sometimes difficult to address the issue of violence without focussing first upon the most urgent issues for the child. Consequently, therapeutic flexibility was an asset as the specific needs of the children and families commonly superseded the objectives of the practicum. Secondly, through practical application, I learned the value of play, and how powerful it can be with respect to engaging children and decreasing their anxiety. Thirdly, I used both qualitative and quantitative assessment and evaluation methods and learned to appreciate their utility. Lastly, I was able to provide a positive adult role model to children and their caregivers, which was supported by comments offered in the feedback forms completed by children and their caregivers.

In summary, this practicum provided the opportunity for self-growth as a social work practioner. For example, I developed stronger interviewing and assessment skills, recognized the value of play, and expanded my repertoire of Theraplay and other directive play techniques. Furthermore, I learned to appreciate

clinical measures to support clinical impressions, the value of supervision in recognition that this work cannot be done in isolation, and the importance of attending to personal needs to offset the risk of vicarious traumatization. Overall, I gained greater confidence in my capabilities as a social worker in working therapeutically with children and employing their parents as partners in the process. While the presenting issue for these families was exposure to family violence, I believe that the knowledge and skills I have developed can be easily transferred to other parent-child populations. In this regard, I believe that my professional work will benefit from the practicum experience by continual application of the knowledge I gained to my ongoing work with families. I feel great satisfaction in having undertaken and completed the challenge of this practicum.

Recommendations

A number of recommendations for future work in this area emerged based upon this practicum experience. From a process perspective, the compilation of an in-depth literature review and the definition of clear objectives and methodology simplified the initial phases of the practical work. An understanding of contemporary research in the field helped structure the process. This foundation of knowledge provided the opportunity to reflect upon the work during each stage of the practicum process and conceptualize the similarities and differences between practicum observations and reports from other researchers. Additionally, an understanding of the common interventions for this population provided a repertoire of ideas and defined the need for more research focusing on structured play based interventions. Finally, this body of knowledge also simplified the task of formulating conclusions for

evaluation, termination summaries and the practicum report. In particular, I was able to use the themes highlighted in the literature to compare and contrast findings and this was very helpful.

There was little difficulty receiving appropriate referrals for this practicum, thus, reflecting the community need for therapeutic services, especially for children who had been exposed to partner abuse. Despite the need for services, it took a number of weeks for potential clients to hear about the call for referrals and for intake sessions to be arranged. As this initial process is extremely time-consuming and emotionally taxing, it is recommended that students incorporate sufficient time for this phase and embark on it as early as possible. In addition, special consideration needs to be given to the childcare and transportation needs of the families as both of these issues presented significant barriers for the families in terms of their attendance. In circumstances where additional resources are required, it is helpful to coordinate with referring agencies to gain their support and assistance in actualizing their client's completion of the individual or group intervention.

In terms of the models of intervention, I would recommend that the parent-child group continue. The combined approach of concurrent mother's and children's groups with a parent-child multi-family group appears to work well. The treatment of families in a systemic manner reinforces the importance of the interrelatedness of the issues for the women and children. Furthermore, by providing therapy in this manner, it reinforces the impact of parental violence upon the family system, rather than tendencies to individualize the problems and pathologize the women and children. I believe that the group size should remain small. Although having only four members

presented somewhat of a risk to the survival of the group, the small size of the group appeared to work well for the children and their mothers. In particular, the small size appeared to contribute to group cohesion, which ultimately led to the group's success. For the group leaders, the small membership enhanced the ability to provide the children with individual attention and respond more effectively to behavioural issues which arose. The small group size also permitted the leaders to understand each family unit on a more meaningful level. For the multi-family group, the small size contributed to the Theraplay activities being more manageable and also provided increased opportunity for leaders to provide assistance and direction to parents through partnering of one leader per family.

While the literature recommends group interventions for children who have been exposed to violence, the structured play based therapy model used individually with the children in this practicum seemed beneficial to the children. Therefore, individual therapy should be considered a viable treatment option, in addition to, or as an alternative to, group counselling. Individual therapy offered the children a personalized, flexible approach that would not have been possible in the group format. It is important however, that the parents of the children be enlisted as partners in their child's therapy so as to maximize the gains for the child and ensure the skills learned in the therapy context are extended into the day-to-day life of the child. As will be discussed next, the needs of the mothers can sometimes outweigh those of their children and thus a comprehensive assessment of their ability to focus on their child needs to occur at intake. I worked with two children on an individual basis and this

was adequate from a learning point of view and also from a time based perspective, given the amount of time it took to meet with the parents of the children.

This practicum report has consistently commented on the importance of working not only with the children who have been exposed to violence, but their non-offending mothers as well. Many of the caregivers have such high needs however, that their issues tend to outweigh those of their children, thus presenting a challenge to the therapy process. In the group intervention, my focus was primarily upon the children's group, however it was difficult to assess and respond to the children's emotions and behavioural problems without a clear understanding of their mother's functioning. Therefore, ongoing supervision meetings and consultation with the leaders of the mother's group was absolutely critical. In addition, it was helpful to coordinate meetings with external agencies involved with the families to discuss additional supports available to assist them and to assist in future planning for the families for after the group terminated.

In the individual work with children, I attempted to address the personal needs of the caregivers, yet often the task was too immense. In retrospect, a referral to a separate therapist may have been helpful. For instance, an idea for future work in this area would be to employ a team of two co-therapists, in which one would focus upon the children and the other would concentrate upon the caregivers. In particular, the therapist would field referrals for children exposed to partner abuse and based upon their assessments, the client would be offered some of a number of interventions. This continuum of services would span from individual counselling for personal needs to family therapy focusing upon the past violence and current parent-child interactions.

The level of caregiver and child needs at intake would determine the type of services initially received; however, assessment would be ongoing so that clients could easily move along the continuum of interventions when appropriate. Yet, a number of potential drawbacks are apparent. Most notably, it would require a great deal of flexibility on the part of the therapists. Additionally, it would also be contingent upon the caregivers' motivation. Based on this practicum experience however, the number of caregivers who wanted to be involved outweighed those who did not.

Finally, the opportunity to have supervision and feedback for both the group and the individual work assisted in deepening the learning and enhanced the overall practicum process. This feedback helped in integrating, understanding, and exploring alternate ways of intervening with the children. Supervision and consultation was therefore critical to the entire process and its value and importance should not be underestimated.

Whether a group format or individual intervention is chosen, there needs to be an opportunity to allow the child to express his or her feelings, to be validated and to have a context of support and healing that will help the child to move on. Incorporating play and playfulness into the therapy session made the process fun and meaningful for both the child and myself.

References

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

Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. Caldwell, & M. Riccuiti (Eds.), *Review of child development research (pp. 1-94)*. Chicago: The University of Chicago Press.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders,* (IV). Washington, DC: Author.

Arnold, L. E. (1978). *Helping parents help their children.* New York: Norton.

Arroyo, W., & Eth, S. (1995). Assessment following violence-witnessing trauma. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 27-42). London: Sage Publications.

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

Barnett, O., Miller-Perrin, C., & Perrin, R. (1997). *Family violence across the lifespan.* London: Sage Publications.

Bilinkoff, J. (1995). Empowering battered women as mothers. In E. Peled, P. G. Jaffe, & J. L Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 97-105). London: Sage Publications.

Black, C. (1981). *Children of alcoholics: It will never happen to me*. New York: Ballantyne Books.

Bloom, M., & Fisher, J. (1992). *Evaluating practice: Guidelines for the accountable professional*. New Jersey, NJ: Prentice-Hall Inc.

Bowlby, J. (1973). *Attachment and loss.* London: Hogarth Press.

Bowlby, J. (1980). *Attachment and loss.* London: Hogarth.

Boyd-Webb, N. (1999). *Play therapy with children in crisis, second edition: Individual, group, and family treatment*. New York: Guilford Press.

Carlson, B. E. (1990). Adolescent observers of marital violence. *Journal of Family Violence, 5,* 285-299.

Davies, D. (1991). Intervention with male toddlers who have witnessed parental violence. *Families in Society: The Journal of Contemporary Human Service, 72,* 515-524.

Dutton, M. A. (1996). Battered women's strategic response to violence: The role of context. In J. L Edleson & Z. C Eisikovits (Eds.), *Future interventions with battered women and their families* (pp.105-124). London: Sage Publications.

Echlin, C., & Marshall, L. (1995). Child protection services for children of battered women: Practice and controversy. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 170-185). London: Sage Publications.

Edleson, J. L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*, 839-870.

Eisikovits, Z., & Winstok, Z. (2001). Researching children's experience of interparental violence: Toward a multidimensional conceptualization. In S. Graham-Bermann, & J. Edleson (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 203-219). Washington: American Psychological Association.

Elbow, M. (1982). Children of violent marriages: The forgotten victims. *Social Casework: The Journal of Contemporary Social Work, 63,* 465-471.

Ezell, E., McDonald, R., & Jouriles, E. N. (2000). Helping children of battered women: A review of research, sampling of programs and presentation of project SUPPORT. In J. Vincent, & E. N. Jouriles (Eds.), *Domestic violence: Guidelines for research-informed practice* (pp. 144-171). London: Jessica Kingsley Publishers.

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.

Fantuzzo, J. W., & Lindquist, C. (1989). The effects of observing conjugal violence on children: A review and analysis of research methodology. *Journal of Family Violence, 4*, 77-94.

Fantuzzo, J. W., & Mohr, W. K. (1999). Prevalence and effects of child exposure to domestic violence. *The Future of Children, 9,* 21-32.

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

Ficaro, R. C. (1999). The many losses of children in substance-disordered families: Individual and group interventions. In N. Boyd-Webb (Ed.), *Play therapy with children in crisis, second edition: Individual, group, and family treatment* (pp. 295-317). New York: Guilford Press.

Garmezy, N., & Masten, A. (1994). Chronic adversities. In M. Rutter, E. Taylor, & L. Hersov (Eds.), Child and adolescent psychiatry: modern approaches. Oxford, England: Blackwell Scientific Publications.

Gewirtz, A., & Edleson, J.L. (2004). Young children's exposure to adult domestic violence: Toward a developmental risk and resilience framework for research and intervention. *Early Childhood, Domestic Violence, and Poverty: Helping Young Children and Their Families*, (6), 1-19.

Gil, E. (1991). *The healing power of play: Working with abused children.* NY: Guilford Press.

Graham-Bermann, S. A. (1992). The kids club: A preventive intervention program for children of battered women. *Unpublished Manuscript.* University of Michigan, Department of Psychology.

Graham-Bermann, S. A. (1998). Preventing domestic violence. In H. Friedman (Ed.), *Encyclopedia of mental health* (pp.1-16). San Diego: Academic Press.

Graham-Bermann, S. A. (2000). Evaluating interventions for children exposed to family violence. In S. K. Ward, & D. Finkelhor (Eds.), *Program evaluation and family violence research* (pp. 191-215). New York: The Haworth Press, Inc.

Graham-Bermann, S. A. (2001). Designing interventions for children exposed to family violence: Applications of research and theory. In S. A. Graham-Bermann, & J. L Edleson (Eds.), *Domestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 237-269). Washington: American Psychological association Books.

Graham-Bermann, S. A., & Brescoll, V. (2000). Gender, power, and violence: Assessing The family stereotypes of the children of batterers. *Journal of Family Psychology*, 14 (4), 600-612.

Graham-Bermann, S. A., & Hughes, H. M. (2003). Intervention for children exposed to Interparental violence (IPV): Assessment of needs and research priorities. *Clinical Child and Family Psychology Review*, 6 (3), 189-204.

Graham-Bermann, S. A., & Levendosky, A. A. (1998). The social functioning of preschool-age children whose mothers are emotionally and physically abused. *Journal of Emotional Abuse, 1*, 59-84.

Groves, B. M., Zukerman, B., Marans, S., & Cohen, D. J. (1993). Silent victims. *JAMA:Journal of the American Medical Association, 269*, 262-264.

Guzzi DelPo, E., & Frick, S. B. (1988). Directed and nondirected play as therapeutic modalities. *CHC,* 16 (4), 261-267.

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

Holden, W., Stein, J., Ritchie, K., Harris, S., & Jouriles, N. (1998). Parenting behaviors and beliefs of battered women. In G. Holden, R. Geffner, & E. Jouriles (Eds.), c*hildren exposed to marital violence* (pp. 289-337). Washington: American Psychological Association.

Holtzworth-Munroe, A., Smutzler, N. & Sandin, E. (1997). A brief review of the research on husband violence. Part II: The psychological effects of husband violence on battered women and their children. *Aggression and Violent Behaviour, 2,* 179-213.

Hughes, H. M. (1982). Brief interventions with children in a battered women's shelter: A model preventive program. *Family Relations, 31*, 495-502.Hughes, H. M. (1988). Psychological & behavioral correlates of family violence in child witnesses & victims. *American Journal of Orthopsychiatry, 18,* 77-90.

Hughes, H. M. (1997). Research concerning children of battered women: Clinical implications. *Journal of Aggression, Maltreatment & Trauma*, 1, 225-244.

Hughes, H. M., & Barad, S. J. (1983). Psychological functioning of children in a battered women's shelter: A preliminary investigation. *American Journal of Orthopsychiatry, 53*, 523-531.

Hughes, H., Graham-Bermann, S., & Gruber, G. (2001). Resilience in children exposed to domestic violence. In S. Graham-Bermann, & J. L Edleson (Eds.), d*omestic violence in the lives of children: The future of research, intervention, and social policy* (pp. 67-91). Washington: 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.

Hughes, H. M., Parkinson, D., & Vargo, M. (1989). Witnessing spouse abuse and experiencing physical abuse: A "double whammy"? *Journal of Family Violence, 4,* 197-209.

Jaffe, P. G., Hurley, D. J., & Wolfe, D. (1990). Children's observations of violence: Critical issues in child development and intervention planning. *Canadian Journal of Psychiatry, 35*, 466-470.

Jaffe, P. G., & Sudermann, M. (1995). Child witnesses of woman abuse: Research and community responses. In S. M. Smith, & M. A. Straus (Eds.), *Understanding partner violence: Prevalence, causes, consequences, and solutions,* (pp. 213-222). Minneapolis MN: National Council on Family Relations.

Jaffe, P. G., Wilson, S. K., & Wolfe, D. A. (1986). *Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence.* Ottawa: Family Violence Prevention Division, National Clearinghouse of Family Violence, Health and Welfare Canada.

Jaffe, P. G., 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,* 157-163.

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

Jaffe, P. G., Wolfe, D. A., Wilson, S. K., & Zak, L. (1985). Critical issues in the assessment of children's adjustment to witnessing family violence. *Canada's Mental Health, 33,* 15-19.

Jaffe, P. G, Wolfe, D., Wilson, S. K, & Zak, L. (1986). Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. *American Journal of Orthopsychiatry, 56*, 142-146.

James, B. (1989). *Treating traumatized children: New insights and creative interventions.* Lexington, Massachusetts: Lexington Books.

James, B. (1994). *Handbook for treatment of attachment trauma problems in children.* New York: Lexington Books.

Jamieson, W., & Hart, L. (1999). *A handbook for health and social services professionals responding to abuse during pregnancy.* Ottawa: National Clearinghouse on Family Violence, Health Canada, Canada.

Jernberg, A. M. (1979). *Theraplay.* San Francisco: Jossey-Bass Publishers.

Jeske, P. J. (1994). Review of the Piers-Harris Children's Self-Concept Scale (The way I feel about myself). In J. C. Impara, & L. L. Murphy (Eds.), *Psychological assessment in the schools* (pp. 344-345). Lincoln, Nebraska: University of Nebraska-Lincoln.

Jouriles, E. N., & Norwood, W. D. (1995). Physical aggression toward boys and girls in families characterized by the battering of women. *Journal of Family Psychology*, 9, 69-78.

Kaduson, H. G., & Schaefer, C. E. (2000). *Short-term play therapy for children.* New York: The Guildord Press.

Kerig, P., Fedorowicz, A., Brown, C., & Warren, M. (2000). Assessment and intervention for PTSD in children exposed to violence. 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. 161-185). New York: The Haworth Press, Inc.

Kirk, D. (1999). *Little miss spider.* Hong Kong: Palace Press International.

Laing, L. (2000). Children, young people and domestic violence. *Issues Paper.* Sydney: Australian Domestic & Family Violence Clearinghouse, 1-28.

Levendosky, A. A. (2000). Mothers' perceptions of the impact of woman abuse on their parenting. *Violence Against Women,* 6, 247-273.

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

Levendosky, A. A., & Graham-Bermann, S. A. (2000). Trauma and parenting in battered women: An addition to an ecological model of parenting. 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. 25-37). New York: The Haworth Press, Inc.

Levendosky, A. A., Lynch, S. M. & Graham-Bermann, S. A. (2000). Mothers' perceptions of the impact of woman abuse on their parenting. *Violence Against Women, 6,* 247-271.

Levy, T. M., & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and Treating attachment disorder in children and families.* Washington, DC: Child Welfare League of America.

Liebermann, F. (1979). *Social work with children.* New York: Human Sciences Press. Lowenstein, L. (1999). *Creative interventions for troubled children & youth.* Toronto: Champion Press.

Lowenstein, L. (2002). *More creative interventions for troubled children and youth.* Toronto: Champion Press.

Margolin, G. (1998). Effects of domestic violence on children. In P. Trickett, & C. Schellenbach (Eds.), *Violence against children in the family and the community* (pp. 57-94). Washington: American Psychological Association.

Margolin, G. & Gordis, E. B. (2000). The effects of family and community violence on children. *Annual Review of Psychology*, 445-479.

Mathews, D. (1995). Parenting groups for men who batter. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 106-121). London: Sage Publications.

McAlister Groves, B. (1991). (unnamed chapter). In Zero to Three/National Centre for Clinical Infant Programs. *Can They Hope to Feel Again? The Impact of Community Violence on Infants, Toddlers Their Parents and Practitioners: A Report from the Final Plenary Session Seventh Biennial National Training Institute* (pp. 20-27). Washington: Author.

McAlister Groves, B. (1999). Mental health services for children who witness domestic violence. *The Future of Children, 9,* 122-132.

Moore, T., Pepler, D., Weinberg, B., Hammond, L., Waddell, J., & Weiser, L. (1990). Research on children from violent families. *Canada's Mental Health, 38,* 19-23.

Munns, E. (2001, September). *An introductory course in Theraplay*. Conference presented in Winnipeg, Manitoba.

Nisivoccia D., & Lynn, M. (1995). Helping forgotten victims: Using activity groups with children who witness violence. *Social Work with Groups*, 18, 75-99.

Osofsky, J. D. (1998). Children as invisible victims of domestic and community violence. In G. Holden, R. Geffner, & E. Jouriles (Eds.), *Children exposed to marital violence* (pp. 95-121). Washington: American Psychological Association.

Osofsky, J. D. (1999). The impact of violence on children. *The Future of Children, 9,* 33-49.

Osofsky, J. D. (2003). Prevalence of children's exposure to domestic violence and child Maltreatment: Implications for prevention and Intervention. *Clinical Child and Family Psychology Review*, 6 (3), 161-150.

Pagelow, M. (1984). *Family violence*. New York: Praeger Publishers.

Papell, C., & Rothman, B. (1980). Relating the mainstream model of social work with groups to group psychotherapy and the structured group approach. *Social Work with Groups, 3*, 5-23.

Paris, S., & Labinski, G. (1986). *Mommy and daddy are fighting*. Washington: Seal Press.

Peled, E. (1997). Intervention with children of battered women: A review of the literature. *Children and Youth Services Review, 19,* 277-299.

Peled, E. (2000). Parenting by men who abuse women: issues and dilemmas. *British Journal of Social Work, 30,* 25-36.

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

Peled, E., & Edleson, J. (1992). Multiple perspectives on groupwork with children of battered women. *Violence and Victims, 7,* 327-346.

Peled, E., & Edleson, J. (1995). Process and outcome in small group for children of battered women. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (chap. 5). Thousand Oaks, CA: Sage.

Pepler, D. J., Catallo, R., & Moore, T. (2000). Consider the children: Research informing interventions for children exposed to domestic violence. In R. Geffner, P. G. Jaffe, & M. Sudermann (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. (1984). *Piers-Harris children's self-concept scale (Revised Manual).* Los Angeles CA: Western Psychological Services.

Porter, B., & O'Leary, K. D. (1980). Marital discord & childhood behavior problems. *Journal of Abnormal Psychology, 8*, 287-295.

Pressman, B. M (1989). Treatment of wife abuse: The case for feminist therapy. In B. Pressman, G. Cameron, & M. Rothery (Eds.), *Intervening with assaulted women: Current theory, research and practice* (pp. 111-121). New Jersey: Laurence Erlbaum Publishers.

Pynoos, R. S., & Eth, S. (1984). The child as a witness to homicide. *Journal of Social Issues, 40*, p. 87-108.

Rabenstein, S., & Lehmann, P. (2000). Mothers and children together: A family group treatment approach. In R. Geffner, P. G. Jaffe, & M. Sudermann (Eds.), *Children exposed to domestic violence: Current issues in research, intervention, prevention, and policy development* (pp. 185-207). New York: The Haworth Press, Inc.

Rivkin, M., & Hoopman, M. (1991). *Fostering resiliency in kids*. Unpublished Manuscript, Western Regional Center for Drug Free Schools and Communities.

Rosenbaum, A., & O'Leary, K. D. (1981). Children: The unintended victims of marital violence. *American Journal of Orthopsychiatry, 51,* 692-699.

Rosenberg, M. S., & Rossman, B. R. (1990). The child witness to family violence. In R. T. Ammerman, & M. Hersen (Eds.), *Case studies in family violence* (pp. 231-253). New York: Plenum Press.

Rossman, B. B. R. (2001). Longer term effects of children's exposure to domestic Violence. In S. A. Graham-Bermann, & J. L. Edleson (Eds.), Domestic violence in the lives of children: The future of research, intervention, and social policy (pp.35-66). Washington, DC: APA Books.

Roy, M. (1977). *Battered women: A psychosociological study of domestic violence.* New York: Van Nostrand Reinhold.

Roy, M. (1988). *Children in the crossfire: Violence in the home-How does it affect our children?* Florida: Health Communications, Inc.

Rubin, P., & Tregay, J. (1989). *Play with them-Theraplay groups in the classroom: A technique for professionals who work with children.* Springfield: Charles C Thomas.

Schaefer, C. E., Jacobsen, H. E., & Ghahramamlou, M. (2000). Play group therapy for social skills deficits in children. In H. Kaduson & C. Schaefer (Eds.), *Short-term play therapy for children* (296-345). New York: The Guilford Press.

Silvern, L., & Kaersvang, L. (1989). The traumatized children of violent marriages. *Child Welfare, 68,* 421-436.

Silvern, L., Karyl, J., & Landis, T.Y. (1995). Individual psychotherapy for the traumatized children of abused women. In E. Peled, P. G. Jaffe, & J. L. Edleson (Eds.), *Ending the cycle of violence: Community responses to children of battered women* (pp. 43-76). London: Sage Publications.

Statistics Canada. (June 2001). Wife assault: The findings of a national survey. *Juristat Service Bulletin, 21* (6), 2-13.

Sternberg, K. J., Lamb, M. E., Greenbaum, C., Cicchetti, D., Dawud, S., Cortes, R. M., et al. (1993). Effects of domestic violence on children's behavior problems and depression. *Developmental Psychology*, 29, 44-52.

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. *Report of the Twenty-Third Ross Roundtable*. Columbus: Ross Laboratories.

Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). *Behind closed doors: Violence in the American family.* New York: Anchor Press/Doubleday.

Sudermann, M. & Jaffe, P. (1998). Preventing violence: School and community-based strategies. In *Canada Health Action: Building on the Legacy* (pp. 276-310). Sainte-Foy: Editions MultiMondes.

Sudermann, M., Marshall, L., & Loosely, S. (2000). Evaluation of the London (Ontario) community group treatment programme for children who have witnessed woman abuse. In G. Holden, R. Geffner, & E. Jouriles (Eds.), *Children exposed to marital violence* (pp. 127-147). Washington: American Psychological Association.

Sullivan, C. M., Nguyen, H., Allen, M. N., Bybee, D., & Juran, J. (2000). Beyond searching for deficits: Evidence that battered women are nurturing parents. *Journal of Interpersonal Violence*, 15, 583-598.

Tomkins, A. J., Mohammed, S., Steinman, M., Marcolini, R., Kenning, M., & Afrank, J. (1994). The plight of children who witness woman battering: Psychological knowledge and policy implications. *Law and Psychology Review, 18,* 137-187.

Toseland, R., & Rivas, R. (1995). *An introduction to group work practice* (2nd ed.). Massachusetts, WI: Paramount Publishing.

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

Werner, E. E. (1990). Protective factors and individual resilience. In S. J. Meisels, & J. P. Shonkoff (Eds.), *Handbook of early childhood intervention.* Cambridge, England: Cambridge University Press.

Werner, E. E., & Smith, R. S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth.* New York: McGraw-Hill.

Wilson, S. K., Cameron, S., Jaffe, P., & Wolfe, D. (1989). Children exposed to wife abuse: An intervention model. *Social Casework: The Journal of Contemporary Social Work, 70,* 180-184.

Wilson, K. J., & Martin, D. (1997). *When violence begins at home: A comprehensive guide to understanding and ending domestic abuse.* Salt Lake City: Publishers Press.

Wilson, K., & Ryan, V. (2001). Helping parents by working with their children in individual child therapy. *Child & Family Social Work*, 6, 209-217.

Wolak, J., & Finkelhor, D. (1998). Children exposed to partner violence. In J. Jasinski, & L. Williams (Eds.), *Partner violence: A comprehensive review of 20 years of research.* 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. A., Jaffe, P.G, Wilson, S. K., & Zak, L. (1985). Children of battered women: The relation of child behavior to family violence and maternal stress. *Journal of Consulting and Clinical Psychology, 53,* 657-665.

Wolfe, D. A., Jaffe, P. G., Wilson, S. K., & Zak, L. (1988). A multivariate investigation of children's adjustment to family violence. In G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. A. Straus (Eds.), *Family abuse and its consequences* (pp. 228-243). Beverly Hills: Sage Publications.

Wolfe, D. A., Zak, L., Wilson, S., & Jaffe, P. G. (1986). Child witnesses to violence between parents: Critical issues in behavioral and social adjustment. *Journal of Abnormal Child Psychology, 14*, 95-104.

Appendix A

Outline of Group Sessions

Session One-Getting to Know Each Other

Overview:

The goals of this session are establishing the reason for the group, introducing the issue of confidentiality, and setting up an environment where participants can talk about themselves and get to know each other.

Goals:

*Introducing leaders to group members and group members to each other
*Identifying the common reason (domestic violence) that all children are in the group
* Getting children to begin to express things about themselves in a supportive atmosphere

Group Content:

1. **Personalized Welcome:** Personalized welcome to each child in the group. Visual agenda is introduced for the session. Snack is distributed.

2. **Circle Time:** Jelly Bean Introductions. Each child is given a non-see through bag filled with jellybeans. Each child takes a turn introducing themselves by saying their name, then picking one colour of jellybean and sharing that information about themselves that corresponds with the legend (red=your age, pink=what school you go to, green-your favourite colour, Yellow=your favourite food. Keep going around the circle until each child has eaten all its jellybeans.

3. **Check in:** Feelings Wheel Check-in. Each child is given an arrow with his/her name on it. Each week each group member will have an opportunity to identify how he or she feel by pointing their arrow to the feeling word on the feelings wheel that best describes how they feel. Explain that new members may join us next week, but after that the group will be closed.

4. **Theme of the Week: Getting to know each other**
   The facilitator establishes that all of the children in the circle have experienced some kind of hurting in their family. Discuss that we will work together to help each other to heal from the hurting we have experienced. Explain that first we will play some games so we can learn everyone's name:

Name Game. Sitting in a circle, each person in turn says his or her name. First go around saying the names. Then go around again, challenging the children to see how fast they can say their names. Finally, go around again, challenging the children to see how slowly they can say their names.
Roller Ball: Group members take turns rolling a ball to one another, asking a question to the person they roll the ball to. I.e., Do you have any pets?
Name Tags. Each child it given a choice to make a nametag or a hat they can wear. It must include their name, but could also include something about themselves, such as what they like to do. For the nametag, each child chooses a colour of construction paper, and folds it in half. Poke two holes at the top, and string yarn through so the nametag fits around the child's neck. The child can then decorate their nametag. For the hat, cut two long strips of construction paper and staple them together, after measuring the child's head. The child can then decorate the hat.
Envelopes. Each child is given a large envelope. Ask them to write their name on it and they can decorate it if they wish. Explain that the envelope is for them to keep any drawings or things they make, and that it will be kept at EHCC.

5. Activity Break

Duck, duck, goose, hug-This is the well-known game, duck, duck, goose, with a twist. The two people running for the space have to hug or shake hands when meet going around the circle.
Simon Says

6.Check out: Explain that each week we will come together at the end of our time together to check out. After check out, their mothers will join us for the second part for snack and games.

Something you liked about group tonight is....
Explain that each week when the mom's join us, one of the mom's and one of the children will share a little about what we did in our groups. Ask for a volunteer to share and help them to know what to say. Tell them that if they forget, they can ask the others for help.
Pass a gentle touch. The leader demonstrates passing a gentle touch to the person next to them. Group members pass the touch around the circle. Each person can then take a turn initiating a gentle touch.

Session Two-Becoming a Group

Overview:

The primary goal of the second session is to enhance each child's sense of belonging to the group. Group cohesiveness is very important for the success of groups for children of abused women. Group cohesiveness is achieved through establishing group rules so that the children feel safe and also through playfulness, humour and fun activities. The children's feelings of trust and safety in the group are a precondition for breaking the secret and fun activities provide children with an immediate gratification that balances the "heavier" violence-related aspects of the group. In this way, group processes involved in providing a positive experience may contribute to the achievement of other major goals.

Goals:

*Build group cohesion and trust
*create nurturing environment
*To become familiar with group participants, structure, and rules

Group Content:

1. **Personalized Welcome:** Introduction of new member. Distribution of snack.

2. **Check in**: Feelings Wheel

3. **Group Rules:** Explain that group rules help us to feel safe. Brainstorm group rules with the children, write rules on poster and have each child sign his/her name to it. Discuss issue of confidentiality with the children.

4. **Theme of the Week: Becoming a Group**

   Name Game: Each child introduces him/herself by putting an action to his/her name. The other group members then repeat the name and action.
   Group Mural: Explain that they are going to create a mural that will be a symbol for the group. Trace each child's hand in a circle around the edge of the paper.
   The children then write their names in their hands and in the fingers they write what they like to do. Then ask the children to fill the centre with a symbol for the group.
   Hot Potato Game: The child holding the "potato" when the singing stops has to answer a feelings question (Lowenstein, 1999).

5. **Activity Break**

   Blanket Merry Go Round
   Stack of Hands with lotion

6. **Check out**

   Something you liked about group tonight…
   Pass a gentle touch

Session Three-Feelings

Overview:

Many children struggle with confused feelings about what has happened in their family. The goal of this session was to help children identify a range of feeling states, to label them, and to practice expressing them. This gives children a chance to name and to express such emotions as fear, isolation, and anger while in a safe atmosphere where other children have experienced similar reactions to difficult events.

Goals:

*Help group members identify, label and express a range of feeling states
*Help children learn about how other children in similar situations feel (i.e., other children in the group).
*Build group cohesion
*Build atmosphere that group is a safe place for kids to reveal difficult emotions
*Build atmosphere that group is a place to receive respectful attention and support

Group Content:

1. **Welcome**
   Personalized welcome/compliment to the child
   Snack

2. **Check in**
   Feelings Wheel

3. **Theme of the Week: Feelings**
   Video: Mad, Sad, and Glad
   Discussion related questions to video
   Candyland Game (Lowenstein, 1999)

4. **Activity Break**
   Cotton Ball Race with Straws

Tug of War-children against leaders

5. **Check out**
   Something you liked about group tonight....
   Volunteer to share with the mom's
   Pass a gentle touch

Session Four-Different Kinds Of Hurting

Overview:
By learning about abuse and different kinds of hurting, children construct a language about violence that allows them to talk about the abuse, share abusive experiences, and assign responsibility for abusive behaviour. This information also enables them to learn that abuse is not okay and that it is not their fault when their parents fight. The goals of this session are for the children to define abuse, distinguish among forms of abuse, and to be able to state that "abuse is not okay" at the end of the session and later on.

Goals:

*Build trust and mutual aid
*To learn that abuse is not okay under any circumstances
*To learn basic definitions of violence and abuse

Group Content:

1. **Welcome**
   Each child is given a personalized welcome/compliment
   Visual agenda is introduced.
   Snack is distributed

2. **Circle Time**
   Check in with feelings wheel

3. **Theme of the Week: Different Kinds of Hurting**

   Discussion: Facilitators discussed the different ways people hurt each other (i.e., physical abuse, verbal abuse, and sexual abuse).

   Puppet Play: Facilitators used puppets to show the children the different types of abuse. At the end of each scenario, the children were asked questions around what type of abuse they witnessed, the responsibility for the abuse, and how the conflict could have been resolved without the use of violence.

   What Hands Can Do: Two large handprints are drawn on large poster board. The children brainstorm a list of gentle things that hands can do and hurtful things they

can do and write them on the hands.

4. **Activity Break**
   Duck Duck Goose Hug
   Feeling faces blindfolded
   Stack of hands with lotion.

5. **Check Out**
   Children shared their thoughts about what they liked about the group session
   Volunteer selected to share with mom's group
   Pass a gentle touch.

Session Five-Fighting in Families

Overview:

Ideally, by the fifth session, the children in the group feel safe enough to open up and share with the group some of their personal experiences of violence at home. Talking about violence that occurred in their homes requires children to remember what happened and to peel away layers of defenses they have constructed over time. While talking about family violence may be stressful for the children, it can also be healing. Drawing and discussing a witnessed violent event allows children to examine some of their thoughts and feelings about the violence, to get support for them, and to learn about the witnessing experiences, feelings, and thoughts of other group members. Even so, expressing feelings tied to traumatic experiences can be a difficult and stressful experience in and of itself, even when it is legitimated and supported. The special pebble given to the children, symbolizes their strength and courage for sharing their story of fighting in their family.

Goals:

*To share some personal experiences related to violence at home
*To have children understand that violent individuals are responsible for their own behaviour.
*To help children understand that they are not to blame for their parents violence.

Group Content:

1. **Personalized Welcome**

2. **Check in**

3. **Theme of the Week: Fighting in Families**

   Discussion: Fighting in families

Read: Mommy and Daddy are Fighting by Susan Paris
Discussion Questions

Abuse Exercise: The children draw a picture of some fighting they have seen or heard in their family. Each child talks about their picture to the group. Present each child with a special glass pebble to symbolize their courage.

Coat of Arms: Each child creates its own coat of arms.

4. Activities

Tug of War
Follow the leader train
Eating treats of various parts of the body.

5. Check out

What I liked about group tonight…
Volunteer reporter
Pass a gentle touch

Session Six-Fighting in Families Should Never Be a Secret

Overview:

The focus in this session is on sorting out the issues of self-blame and guilt in the face of family violence, while establishing a clear sense of who is responsible for the violence. Myths about family violence are explored, i.e. children need to learn that individuals are responsible for their own behaviour and that their mother's safety is a community concern, not a child's responsibility.

Goals:

*To break the secret of abuse in their families

*To build and strengthen positive associations with each child's gender

*To clear up cognitive distortions related to violence, responsibility and gender

Group Content:

1. Personalized Welcome

2. Check in

3. Theme of the week: Fighting in Families Should Never be Kept a Secret

Discussion: What is a secret? Discuss difference between good secrets and bad secrets. Introduce the idea of secrets about family violence.

Read Book: Clover's Secret

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

Breaking the Secret: Children discuss how the secret of violence was broken in their family.

Responsibility for Violence: Kids sometimes think it is their fault when their parents fight and sometimes adults who are hurt think that it is their fault. For example, some kids might think, " If my mom didn't talk back to my dad and argue with him she wouldn't get hit." Or kids think that if they behaved better then their dad's wouldn't hurt their mom's. It is NEVER the kid's fault when parents fight. It is the fault of the person who does the hurting. Because if someone is mad then maybe he could talk about it instead of hurting someone. Hurting someone is a choice and people can choose not to hurt others.

Puppet Play: Facilitators act out scenarios of abuse and violence. Children are told that violence was a choice. They are encouraged to think of ways the puppet could have managed it's anger and then their ideas are acted out.

Myth Game: The kids all form one team and are shown statements about woman abuse. They must decide as a team if the answer is yes or no and why. If the team answers correctly they get a cheer and points are recorded on a chart. At the end of the game, points are added up and children are given candy in the amount of the points they earned.

3. Activity Break:

Slime
Pop the Bubble
Popcorn Throw
Make Ghosts

4. Check Out

What I liked about group…

Volunteer reporter
Pass a gentle touch

Session Seven-Mixed Up Feelings

Overview:

Many children struggle with confused, mixed up feelings about what has happened in their family. The goal of this session is to help children to identify a range of feeling states, to label them, and to practice expressing them. This gives children a chance to name and to express such emotions as fear, isolation, and anger while in a safe atmosphere where other children have experienced similar reactions to violence in the family. Group leaders continually reaffirm the legitimacy of all feelings and of their appropriate expression. In addition, the activities such as story telling and drawing help normalize the children's response to traumatic events while giving support for and voice to the appropriate expression of hard to grasp emotions.

Goals:

* For children to learn a range of emotions
*For children to learn it is normal and acceptable to have more than one feeling
*For children to practice expressing mixed feeling states

Group Content:

1. Personalized welcome

2. Check in: Feelings Wheel

3. Theme of the Week: Mixed Up Feelings

Discussion:

Sometimes people have mixed up feelings. Sometimes you just don't know how you feel. You have a bunch of feelings. Other times we might have more than one feeling at the same time. For example, if I was in a car accident I might be really scared, because I could have been hurt (put down several cartoon faces of a scared person). I might also feel a little angry that someone hit my car (put down a smaller number of angry looking cartoon faces). I might also feel relieved that no one was hurt (put down a smaller number of relieved cartoon faces), and I might feel sad if my car was smashed up (put down one picture of a sad cartoon face).

Kids often have mixed up feelings when their moms and dad's break up. They might feel very sad that their mom and dad don't live together anymore, and they might miss

their Dad. But sometimes they also feel relieved that the fighting has stopped and no one is getting hurt.

Read: Mom and Dad break up by Joan Singleton Prestine.

Activity: Colour Your Life

Relaxation and Imagery: Have children spread out around the room. Ask them to relax their bodies starting with toes and working up.

- Ask the children to clench their toes, and release them. Repeat this. Ask them to wiggle their toes.
- Ask the children to rotate their right foot using their ankles. Repeat this for the left foot.
- Ask the children to use their right hand and make a tight fist, then release. Repeat this. Repeat for the left hand.
- Ask the children to slowly roll their heads from side to side. Now that their bodies are relaxed, read Being a Colour by Maureen Garth.

4. Activity Break:

Tunnel
Peanut Butter and Jelly
Taste Test

5. Check Out:

Something you liked about group tonight....
Volunteer to share with mom's group
Pass a gentle touch

Session Eight-Feeling Afraid

Overview:

This session was devoted to the identification of things children are afraid of, and things that children used to be afraid of but aren't anymore. The goal was to establish a normative list of the variety of things that children are often afraid of with an eye toward being able to identify the fears of children who have been exposed to parental violence. By doing this in a group format, the children learn that they have similar worries and concerns and that most children feel afraid and worried when their parents fight.

Goals:

*To help identify the normativeness of fears, especially fears about family violence

*To help kids feel empowered by letting them see that they've overcome some previous fears

Group Content:

1. Personalized Welcome: Snack and Agenda

2. Circle Time: Feelings Wheel

3. Theme of the Week: Feeling Afraid

   Read: Feeling Afraid by Joy Berry

   Discussion: Put the following questions in a bag and have each child pick a question. If they answer it correctly they get to pick a treat from the treat bag.

   How did Kim hurt his arm?
   How did he feel when he was climbing the tree? And when he was at the hospital?
   What kinds of things make kids feel afraid?
   Do you know anybody who does not feel afraid at least some of the time? (Message is that everyone feels afraid at least some of the time).

   Activity: Body Tracing. Trace each child's body on a large piece of paper against the wall. Have each child use markers or stickers to show the way the body reacts to being afraid. These are:

   a) Your heart might beat faster
   b) You might breathe harder
   c) You might sweat more
   d) Your stomach might feel upset
   e) Your muscles feel tense
   f) You might feel weak
   g) You might suddenly need to go to the bathroom

   Activity: Drawing. Draw something children are afraid of and present to the group.

   Activity: Safety Planning. Introduce the idea that once we are able to recognize The signs that tell us we are afraid, we need to do something to help us feel safer.
   Have a general discussion about the kinds of situations which kids may encounter
   In their lives that might make them feel afraid. Help the children think of times
   That they felt the need to be safe and explore how they secured safety for

Themselves. Write down the ideas on flipchart. Then give each child a copy of the handout "Personal Protection Plan" and have them complete it.

4. Activity Break

   Shaking All Over
   Pretending we are balloons
   Emotional Statues
   Telephone

5. Check out

   What I liked about group....
   Volunteer reporter
   Pass a gentle touch

Session Nine-Angry Feelings

Overview:

Anger is usually the most familiar feeling for child witnesses of domestic violence. Often it is a secondary feeling that masks other feelings such as shame, fear, and pain. It is also a feeling connected most immediately with the eruption of violence. This session was devoted to exploring anger. Of particular interest, was sorting out the expression and management of anger, helping children to identify their warning signs of anger, and the introduction of a variety of techniques for expressing anger in safe and appropriate ways.

Goals:

*To learn that all feelings, including anger, needs to be acknowledged and felt
*To know it is okay to express all feelings in a group
*To recognize one's own expression of anger
*To learn to differentiate between appropriate and inappropriate expressions of anger

Group Content:

1. **Personalized Welcome**

2. **Circle time**: Feelings Wheel check in

3. **Theme of the week**: Feeling Angry

   Story: Feeling Angry by Joy Berry.

Discussion: Each child picks a question out of a bag pertaining to anger, and for each answer they rewarded with a jellybean.

Draw what anger looks like to you

Safe ways to express anger worksheet. When I get angry I can…..

Volcano: Each child is given a tall glass jar filled with baking soda and covered in tin foil to replicate a volcano. Each child is then given vinegar to pour in which will make it erupt. Discussion takes place about how if we keep our anger inside it can build and erupt, just like a volcano.

Relaxation and Imagery Exercises

4. **Activities**

Shaking all over
Balloon-inflate/deflate enactment
Deep breathing

5. **Check out**

What I like most about group tonight….
Pass a gentle touch

Session Ten-Families

Overview:

Children learn how to interact with others from the relationships they experience and observe in their own families. There are strengths and drawbacks to being a member of any family, but there is little opportunity for most children to think about and share information about family relationships. Several exercises help children to explore what it means to be a family. First, by drawing a picture of their family doing something together, children can share their impressions of the strengths and the drawbacks of their current family situation. Second, the group members are asked to imagine what they would ask for if they were granted three wishes for their family today. Finally, the children can draw a picture of what their own family will be like when they grow up, and can share a story about what is going on in the picture with the group. Ultimately, the goal of this session is to help the children imagine future positive families.

Goals:
*For children to learn about different family types
*To help children imagine future positive families

Group Content:

1. **Personalized Welcome**
   Agenda
   Advise children of group ending soon

2. **Circle time**

3. **Theme of the week: Families**

   Discussion about different kinds of families, that no one type of family is better than the other, and that families can change over time. Children were asked questions about changes that occurred in their families and their feelings around it.

   Activities:

   1.Each child creates a picture of their family using cutouts of people and faces

   2.Three wishes. Children are asked to imagine what they would ask for if they were given three wishes for their family today.

   3.Children draw a picture of what their own family will be like when they grow up.

4. **Activity Break**

   Feelings Darts
   Bowl of bubbles

5. **Check out**

   What I liked about group…
   Pass a gentle touch……

<u>Session Eleven-Getting Along with Others</u>

Overview:

This second to last session is an opportunity to begin the process of closure for the children. The children need a way of separating which allows for the expression of their many feelings about being in the group and ending the group. Allowing the children to be in control of some of the process of separation is crucial given that many events in their lives have been very much out of their control. In addition, because children who been exposed to violence have lived their lives in secrecy, they

can be confused and fail to learn healthy communication and social skills. The result can be anger, frustration, and an inability to get their needs met by others around them. This session also presents an opportunity for the children to explore their thoughts and feelings around relationships with others outside of their families and to learn social skills which ultimately can assist them in forming and maintaining healthy relationships with peers.

Goals:

* For children to learn conflict resolution skills
*For children to practice social skills with their peers
*To prepare the children for termination

Group Content:

1. **Personalized Welcome**

2. **Circle Time**: Check in with feelings wheel

3. **Saying Good-Bye**. Discuss feelings associated with saying good-bye.

   Craft: Children decorate terracotta plant pots and make flowers to put in them.

4. **Theme of the Week**: Getting Along with Others

   Brainstorm: What makes a good friend

   Magic Carpet Ride: Liana Lowenstein (1999)

5. **Activity Break**

   Bowl of Bubbles
   Cotton Ball Tickles
   Mother May I

6. **Check out**

   Something you liked about group tonight....
   Volunteer to share with mom's group
   Pass a gentle touch

Session Twelve-Saying Goodbye

Overview:

The goal of this session is for the children to realize that this is the end of group and to give them the opportunity to express some related emotions. In addition, it is important for the children to acknowledge his or her accomplishments and to feel proud of himself/herself. This is done by group leaders identifying for each child their achievements in group, for example being brave enough to participate in the group and deal with painful issues, for being good listeners and friends to other group members, for learning new ideas, and for expressing uncomfortable thoughts and feelings. The purpose of reviewing the group content over the past twelve weeks is to allow the children to express their opinions and feelings about the group and to give group leaders a sense of what they have learned in group. This is an opportunity to empower the children by giving them the message that their opinions and ideas are valid, important, and useful.

Goals:

*To consolidate group learning by reviewing past sessions in group
*To realize that this is the end of the group and to express some related emotions
*To acknowledge his or her accomplishments and to feel proud of him/herself

Group Content:

1. **Welcome**

2. **Check in.** Review what was done over the pat twelve weeks. Go around the circle and have each child state how they are feeling and to identify what they like most about group. Group leader tells each child: Something I will remember about you...

3. **Terracotta Pot Craft for the mothers**. Children finish decorating a terracotta plant pot with different coloured foam flowers and buttons. Styrofoam and grass are placed in the pot and the children put two flowers in, one tall one and one short one. The children are told that the large flower represents their mother and the small flower represents them. The craft as a whole symbolizes the parent child relationship and how it grew and flourished over the course of the group.

4. **Show and Tell**

5. **Check out**

6. **Party with the mothers**: Cake, presentation of gifts, presentation of certificates, games.

Appendix B

Client Satisfaction Questionnaire for the Children's Group

Date_____

Name of Leader (s) _____

1. What I liked about the group_____
2. What I learned in the group_____
3. How I am feeling now_____
4. My favourite part of the group_____
5. What I would change about the group_____
6. I would recommend this group to a friend Yes No
7. I liked the place we met Yes No
8. Other comments_____

JC/03

Appendix C

Client Satisfaction Questionnaire for Individual Sessions

Date_____

Name of therapist_____

1. When I first came here I felt_____
2. Now I am feeling_____
3. The things that are different for me are_____
4. My parents(s) or caregiver(s) notice this about me now_____
5. What I liked the best about my sessions_____
6. What I would want to be different_____
6. Other comments_____

JC/03