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A Group Approach to Addressing the Separation Experiences of Children in Care

A Practicum Report Submitted to

The Faculty of Graduate Studies

University of Manitoba

In Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

by

David B. McGregor

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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David B. McGregor

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

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Abstract

A potential for harm exists whenever a child is separated from his or her parents through an apprehension and placement into foster care. Child welfare has the responsibility to support those children it places into care and their alternative care givers through the experiences of separation and loss. For many children, placement into care is a traumatizing experience. The children entering care present with behavioural and emotional needs which challenge and stress their care givers. The care giver's ability to support a child's needs during placement has a significant impact upon the trauma experienced by the child. The following practicum reports on a 10 week group intervention for children in care of a rural child welfare agency, which provided participants with the opportunity to talk about their separation experiences and feelings of being in care. Extensive reviews of attachment, separation and loss theories are examined to consider their implications for working with children in care. A group intervention with children at a latency-early adolescent development level is thoroughly presented. The challenges in working with the care givers of these children through a parallel group process are also explored. Four measures are used to evaluate the effectiveness of the group, and several recommendations are considered for further group interventions.

Table of Contents

List of Tables

Appendices:

Introduction

The Problem Area

Child welfare practitioners can experience a Solomonic predicament when doing protection work.

> Taking a child into care is like starting a war: it is easy to fire the first shot, but it is not without risk, since there is no telling where the process that has been unleashed will end. But there are some families that are so abusive and neglectful...that the decision not to remove their children and place them in the care of an alternative family with the capacity to meet their needs is, in effect, a decision to submit them to even a longer and more dangerous period of neglect and abuse. (Steinhauer & Chappel, 1998, pp. 7-8)

In those situations where the decision is made to remove a child, the child welfare system has the responsibility to do so in the least detrimental way and to reduce the impact of the separation and loss experience through sound practice which helps the child and his or her family to cope with the experience (Steinhauer, 1991).

A potential for harm exists whenever a child is separated from his or her primary care giver. "The decision to remove a child from the family in order 'to protect' the child must be weighed against the possibility of traumatizing the child in the foster-care situation" (Grigsby, 1994, p. 271). For the child, the "trauma of separation and placement generates feelings of abandonment, helplessness, anger, fear of abandonment by the

parent, and fear of death of the parent" (Grigsby, 1994, p. 272). Reflecting back over apprehensions that I have been involved with in my child protection career, I am reminded of the many impacts that children face which result from the decision to remove them from their families. For some of these children, the experience has been traumatizing.

Children who come into alternative care often present with behavioral and emotional needs which challenge and stress their care givers (Fanshel, Finch, & Grundy, 1989; Fanshel & Shinn, 1978; Jewitt, 1982; Lawder, Poulin, & Andrews, 1986; McKenzie, 1997; Pilowsky, 1995; Steinhauer, 1991). McKenzie states:

> Children who have been abused and neglected seriously enough to be removed from their families and placed into foster care, do have long term service needs...[which puts] an obligation on us to prepare and help their [foster] families with this predictable reality. (1997, p. 3)

Care givers (foster parents) have a critical role in responding to the emotional needs of the child(ren) in their care (Palmer, 1995). The coping and parenting skills required by the care giver(s) to support the child's emotional needs will strain their family system. Insufficient placement resources, training, and supports for foster families can lead to poor placement decisions, placement breakdowns, and subsequent moves for the child. The risk of placement drift for the child(ren) in care is thus increased (Sparrow Lake Alliance, 1996; Steinhauer, 1991). Such an experience for a child in care is not unusual (Pardeck, 1984; Taber & Proch, 1987) and comes "with consequent destructive effects on children" (Palmer, 1990, p. 227). Palmer's (1995) study highlighted these

issues and problems with the child welfare system and the critical need to support children and their care givers through the experiences of apprehension and placement.

The apprehension of children in child protection work is often crisis bound, emotionally intense, involving conflict, and traumatic for the child. Even in those situations where the placement of a child is on a planned, consensual basis there are the separation experiences for the child and family to contend with plus the risks to the child of being in care. Clearly, coming into agency care is a significant event in a child's life which needs to be understood, acknowledged, and supported.

The focus of this practicum was in developing a group intervention through which issues arising from this experience could be addressed. My learning objectives for this practicum included: (a) developing my clinical skills in working with groups of children in the latency- early adolescent developmental levels; (b) increasing knowledge and understanding of separation and loss experiences for children coming into care; (c) developing intervention skills working with children who have experienced loss and separation trauma as a result of coming into agency care; (d) developing skills to support the care givers of children in care who are experiencing emotional and behavioral issues as a result of coming into care; and (e) evaluating if this intervention can support and assist children in care and their care givers around dealing with the separation and loss trauma from coming into alternative care.

Chapter One: The Separation Experiences of Children in Care

Literature Review

Introduction

It is accepted in child welfare that children who come into care need help dealing with separation and loss issues (Fahlberg, 1979; Jewett, 1982; Palmer, 1995; Steinhauer, 1991). Children who enter foster care will experience separation and loss from one or both of their parents. A child's sense of continuity and stability with his or her family will be disrupted and forever changed by the experience of coming into care (Siu & Hogan, 1989).

A child's separation and loss experience resulting from coming into agency care is affected by the care and supports received following the apprehension and placement. "Parent-child separation, the breaking and remaking of attachments, makes the care experience central in the foster child's emotional life" (Rosenfeld et al., 1997, p. 452). Children go through a process of grieving and mourning when they are separated from their birth parents (Steinhauer, 1995). This process is either inhibited or supported by the people and systems surrounding the child.

Palmer (1995) raises several issues concerning the support children receive when they enter care which can increase or decrease some potential impacts of separation and loss. What are they told about why they are in care? Who tells them and when are they told? How long is it until they see their parent(s) again? Does the child feel responsible or guilty about coming into care? To whom is blame assigned? What are the conditions

surrounding the apprehension? Do these conditions support or inhibit the child's active grieving? What is the child's experience of loss? The answers to these and other questions provide an understanding of what the experience has been like for the child and whether his or her attachment needs were supported through the experience.

The potentially traumatic impact of separating a child from his or her natural parent(s) to protect the child has become a critical variable considered in child welfare practice. Hegar (1988) highlights changes in child welfare practice (e.g., the use of family preservation and family strengthening approaches) which seek to avoid the unnecessary placement of children.

As well, removing a child from his or her family exposes the child to other systemic risks which have to be considered in the decision to remove a child. Placement resources for children who come into care are often limited, inadequate and overburdened to meet the high needs that many children present when entering care (Rosenfeld et al., 1997). This critical systemic problem in child welfare contributes to the breakdown of placements which can result in the child experiencing multiple placements and entering a cycle of limbo within the system (Sparrow Lake Alliance, 1996). A child who experiences placement drift is exposed to further emotional and psychological trauma (Steinhauer, 1991).

Fahlberg (1979), Hegar (1988), Palmer (1995), and Steinhauer (1991) promote best practice principles for those families where children do enter care. These principles are based upon this understanding of the impacts of separation upon children and families

and include: (a) keeping the placements as short as possible by returning children when protection plans are in place; (b) encouraging family visitations; (c) ensuring consistent workers; (d) adopting family inclusive practices, i.e., involving the family and extended family in all aspects and decision making regarding the child coming into care; (e) working to train and support foster parents; (f) using kinship care; (g) keeping siblings together when possible; and (h) seeking permanency planning for all children who enter care. Permanency planning is understood as "the need to maximize historical continuity and to minimize the period that any child remains in limbo" (Steinhauer et al., 1995, p. 2).

The following literature review will outline the significance of attachment, separation and loss theories in understanding and supporting the experiences of children who are apprehended from their natural parents and enter the foster care system. As well, the review will look at the theory and issues related to group work interventions with children who are in the latency to early adolescent developmental stage.

Attachment Theory

"Attachment theory provides a basis for and is supported by theories concerning separation and loss" (Palmer, 1995, p. 19). Attachment, loss and separation theories contribute to the social worker's comprehension of children's connections with their parents, families, foster care providers, and others who play important roles in children's lives. With this knowledge and experience child protection workers can better understand and support a child's behavior associated with separation and loss resulting from an

apprehension (Worden, 1982). As well, the child welfare system may achieve improved decisions, practices and outcomes for those children and their families with whom they are involved.

Two of the primary contributors to attachment theory are John Bowlby and Mary Ainsworth. John Bowlby's early research focused upon mother-child separation and this was influenced by the work of one of his students at the Tavistock Clinic, James Robertson. Robertson's observations of young children in a hospital who were separated from their parents helped Bowlby to direct his research toward the nature of the early relationship between infant and mother. Bowlby appreciated the value of naturalistic observations from Robertson's hospital data and his subsequent ethnological approach to theoretical development was inspired with this tradition of primary observation. From this early work, Bowlby's theory of attachment came to represent the psychological connection between people that permits them to have significance to each other (Bowlby, 1969).

Mary Ainsworth joined with Bowlby at the Tavistock Clinic and in her research focused upon very young children. Ainsworth also made naturalistic observations of mothers with their infants in several different settings, from villages in Africa to American inner cities (Bretherton, 1991, 1995). She distinguished attachment as the young child's need to maintain closeness and contact with an attachment figure and the child's experiencing distress upon separation from his or her attachment figure, pleasure upon reunion and grief at loss (James, 1994).

What is attachment?

James defines attachment as "a reciprocal, enduring, emotional, and physical affiliation between a child and a care giver" (James, 1994, p. 2). An attachment relationship results from the process of mutual need fulfilling interaction that develops early in life between an infant and his or her primary attachment figure, usually the mother. Fahlberg (1979) labels this interaction as the Arousal-Relaxation Cycle. In this interaction, an attachment relationship develops when the primary care giver can both perceive and then meet the needs of the infant (Steinhauer, 1995).

Bayless (1990), Fahlberg (1979), and others describe how the nature of attachment relationships grow and develop. Trust and security are nourished by the care giver who responds positively to the young child's expression of need. This fulfilling of basic needs results in the child being able to both relax and enjoy his or her interaction with the care giver. It also promotes the development of self worth and self esteem in the child as the care giver further initiates interactions with the child seeking his or her positive response thus reinforcing this cycle of reciprocal interaction between the care giver and child. Fahlberg (1979) identifies this process as the Positive Interaction Cycle. Through this interaction, the child develops confidence and trust in a relationship which meets his or her basic needs and this experience will extend to other relationships.

A healthy attachment relationship between the child and care giver plays a significant role in the positive development of a child by giving the child a secure emotional base from which to explore his or her world (Bayless, 1990). "A secure

attachment evokes feelings of belonging, acceptance and trust" (Steinhauer et al., 1995, p. 45). The results of secure attachment relationships are many and include: (a) the child learning to soothe self; (b) the child learning to control his or her aggressive tendencies to protect its significant relationships; (c) the child having the confidence to take risks because she or he will know there is a secure base to fall back on; (d) a child's self esteem growing as he or she feels valued and worthy of someone else's affection; (e) the child developing language and other communication skills; (f) the development of trust and a positive "world view"; and (g) the child learning to be self-reliant (Rycus, Hughes, & Ginter, 1988; Steinhauer, 1995).

There can exist for the child, a hierarchy of attachments (Steinhauer, 1995) as children can learn to have multiple attachments. However, all children, to survive, require a primary attachment figure (care giver), and this becomes the person to whom a child turns for comfort and security when anxious, threatened or hurt. As the child's sense of security and confidence grows, he or she can leave the attachment figure for longer amounts of time but always returning for support and safety. When the attachment figure is gone or threatens to leave, the child responds with anxiety and emotional protest (Bowlby, 1973). These reactions from the child upon separation from his or her attachment figure are called attachment behaviors, which are those behaviors designed to decrease distance, and maintain proximity and contact with the attachment figure (Bretherton, 1991). If attachment behaviors are unable to restore the attachment figure, then the child enters grieving and mourning and displays withdrawal, apathy and despair

(Bowlby, 1973).

Ainsworth's naturalistic observations in Uganda and Maryland of infant-mother attachment patterns and children's exploratory behavior contributed to this awareness of the child's need for a secure base from which to explore his or her environment and to the understanding of attachment behaviors. Ainsworth advanced her research on attachment and separation when she developed a laboratory observation procedure (the strange situation) consisting of scenarios in which the care giver (again, usually the mother) and a female stranger interact with, depart from, and reunite with the infant in an environment which offers the child opportunities for exploration (Main, 1995; Steinhauer, 1995).

In conducting this research, Ainsworth's focus was drawn to the understanding and meaning of the reunion behaviors between the child and mother after the introduction of the treatment effect of the strange situation. This study of the child's attachment behavior evolved into the Strange Situation Classification System (Bretherton, 1995; Main, 1991) which can be used to assess attachment in children up to two and a half years of age. How the child behaves in the strange situation is believed to provide clues as to the nature of the attachment relationship between the child and his or her care giver (mother). Ainsworth's team had:

> closely observed mothers and children in their homes [during the first year of life], paying careful attention to each mother's style of responding to her infant in a number of fundamental areas: feeding, crying, cuddling, eye contact and smiling...and [because of this careful observation], they were able

> to make specific associations between the babies' attachment styles and the mothers' style of parenting. (Karen, 1990, p. 36)

Assessing a child's attachment is important to both understanding the child's connection to his or her parent, the potential impact of any separation, and to evaluate the ability of the child to form new relationships (Bayless, 1990).

The types of attachment relationships were classified by Ainsworth (Grigsby, 1994; Main, 1991; Steinhauer, 1995) as: (a) secure attachment (Ainsworth's Type B); (b) insecure/avoidant attachment (Ainsworth's Type A); and (c) insecure/ambivalent attachment (Ainsworth's Type C). A fourth classification of disorganized/disoriented attachment (Main's Type D), was developed later by Mary Main (1991). There are also subcategories developed within each of the four types.

The child's behaviour in each of the four classifications of infant attachment and the corresponding care giver behaviour which evoked that attachment pattern are described as follows:

1. Secure attachment (Type B) is where the infant shows signs of missing the parent on departure, seeks proximity upon reunion and then returns to play. This pattern is believed to be related to the parent's sensitivity to infant signals.

2. Insecure/avoidant attachment (Type A) is where the infant shows few signs of missing the parent and actively ignores and avoids the parent upon reunion. This pattern is believed to be related to the parent's insensitivity to infant signals.

3. Insecure/ambivalent attachment (Type C) is where the infant is

distressed and highly focused upon the parent and cannot be settled by the parent upon reunion, often expressing anger and failing to return to play. This pattern of behaviour is believed to be associated with insensitivity and unpredictability of parental responsiveness to infant signals.

4. Insecure-disorganized/disoriented attachment (Type D) category was developed in 1990 as researchers found many children whose attachment behaviour included a diverse array of behaviors that did not fit into any of Ainsworth's A, B, C types. "Our analysis revealed, instead, that what these unclassifiable infants shared in common was bouts or sequences of behaviour that seemed to lack a readily observable goal, intention, or explanation" (Main, 1991, p. 423). Steinhauer (1995) believes that Type D attachment patterns are the most commonly seen among children in child welfare and that this is a pattern which suggests the child is frightened by his or her care giver and that the child has not developed a strategy yet to deal with his or her anxiety. The parental behaviour for Type D is unknown.

Poor or inconsistent parenting experiences can lead to anxious or tenuous attachments. Three types of attachment disorders identified in children are (Bayless, 1990): (a) the non-attached child, who has never formed a significant primary attachment; (b) the inadequately or anxiously attached child, who has had primary attachments repeatedly disrupted and broken; and (c) the traumatized child, who has experienced abuse and/or neglect and is unable to trust. Specific behaviors of children with attachment problems include (Bayless, 1990; Rycus et al., 1988): (a) aggressive behaviors;

(b) control battles; (c) chronic anxiety; (d) delayed conscience development; (e) indiscriminate affection; (f) lack of self-awareness; (g) over-competency; (h) poor eye contact; (i) withdrawal; (j) low self-esteem; and (k) inadequate social skills. These are behaviors that are often observed among the foster child population (Pilowsky, 1995).

A child's attachment experience is believed to lead to an internalized collection of expectations and assumptions which will influence subsequent relationships throughout the child's life (Parkes, Stevenson-Hinde, & Marris, 1991). Bowlby (1973) states:

> No variables . . . have more far-reaching effects on personality development then have a child's experiences within his family: for, starting during his first months in his relation with both parents, he builds up working models of how attachment figures are likely to behave towards him in any variety of situations, and on those models are based all his expectations, and therefore all his plans, for the rest of his life. (p. 369)

However, critics of attachment theory believe that a child's development is not solely determined by the quality of attachment in the first few months or years of life and that other aspects of parenting are also important.

Kagan (1984) argues that genetic and temperament factors play an important role in relation to the fit between parent and child. Further, that by focusing upon the primary care giver (usually the mother), attachment theorists have ignored the role of the father and blame mothers for all "psychiatric sorrow" in their children. Kagan also suggests that the strange situation is based upon a very small sample (i.e., 23 Baltimore families) that

was not very representative.

Steinhauer (1995) also believes that there is not a direct relationship between attachment experiences and later psychopathology, though insecure attachment increases the risk. He contends that attachment has a more indirect impact on a child's development which is further influenced by several other contextual factors, which include: (a) family adversity (family psychopathology, marital pathology, stress levels, socioeconomic levels); (b) parenting styles; and (c) child characteristics (temperament and "goodness of fit" to parental gender, parental attributions, and parenting style).

He and others have developed an updated assessment instrument, the Assessing Parenting Capacity Model (Steinhauer et al., 1995), for the child welfare practioner that attempts to consider this "fit" between parent and child. This tool is intended for use in assessing the parenting capacity of families to assist in making improved child protection decisions. It focuses upon the context for the family (cultural and current stressors); the child (developmental progress); the child/care giver attachment relationship; and parent factors (impulse control, acceptance of responsibility, parenting behaviors, relationship to the community, and the use of clinical interventions) to develop a family parenting profile. This approach improves upon Ainsworth's observing of the interaction between parent and child in an artificial, strange laboratory setting which has an impact upon the interaction observed. As well, Steinhauer's tool is completed in a contextually sensitive manner and is helpful for assessing the attachment relationship between a parent and an older child.

The assessment of the attachment relationship between the child and his or her care giver is composed of four parts, all of which must be completed. Part A is an assessment of the predominant pattern of the care giver-child relationship through observation and ratings of the "child's usual or habitual responses when in a familiar and comfortable situation" (Steinhauer et al., 1995, p. 49), and is divided into 4 age sections; (a) infant to 12 months; (b) toddlers 1 to 2 1/2 years; (c) pre-schoolers 2 1/2 to 5 years; and (d) children 5 years and older. Part B is a survey of the child's key relationships. Part C enquires about any separation and losses the child has experienced. Part D involves understanding the care giver's own experiences of being parented and "his or her current view of how the experience in the family of origin is currently affecting his or her feeling and functioning" (Steinhauer et al., 1995, p. 53). All four parts are completed to provide an assessment of the attachment relationship between the child and care giver. The authors are careful to caution users of the model that the quality of the assessments made "are only as good as the skill, objectivity and sensitivity of the assessor" (Steinhauer et al., 1995, p. 18).

Werner and Smith (1992) identified through their extensive study of resilience factors in children that it is possible to recover from early experiences of adversity and trauma. The key factor in a child's bouncing back from early deprivation was in "having at least one person who accepted them for themselves, who rewarded them for helpfulness and cooperation, who gave them some challenges, who encouraged their interests, who contributed to their self-esteem, or who provided a model for living" (Guy, 1997, p. 20).

Maier (1994) states that children in care:

> have a good chance for a promising future, if they can find selected alternative persons who can stand by and care actively for them. Such later positive attachment connections can be readily traced to the quality of care experience in foster care or other alternative forms of group living. (p. 36)

This positive framing of the role attachment can have in a child's development is what sustains those who work with damaged children in care. There is hope to rebuild and repair a child's ability to form an attachment relationship.

Loss and Separation Theories

Bowlby (1973) studied the behavior of infants during separation and at reunion with their care giver. He defined separation and loss as where the "subject's attachment figure is inaccessible, either temporarily (separation) or permanently (loss)"(p. 178). He focused upon the impact of separation from their mother on young children's emotional behavior and highlighted the distress of children during separation and their anxiety after it. If a child's attachment behaviors were unable to restore the proximity to the attachment figure, then the child began to grieve and mourn and present behaviour characterized by withdrawal, apathy and despair. Attachment behavior is "any form of behavior that results in the person attaining or retaining proximity to another individual" (Grigsby, 1994, p. 270). Withdrawal behavior is where the child seeks to increase the emotional distance from persons and objects and is used by the child as an escape and/or avoidance defense. The child employs withdrawal behaviors after repeated experiences

where the child's attachment behaviors are not successful in achieving reunion with his or her attachment figure (Grigsby, 1994).

Bowlby (1973) describes the impacts of separation and loss of the attachment object (usually the mother) as potentially traumatic:

> Experiences of separation from attachment figures, whether of short or long duration, and experiences of loss or of being threatened with separation or abandonment - all act . . . to divert development from a pathway that is within optimum limits to one that lie outside them. (pp. 369-370)

Bowlby (1973) identified anxiety and fear as primary feelings aroused by separation and loss. Both responses were found to operate together in children's behavior during separation and loss experiences and served a protective function. The child's basic survival needs motivated his or her instinctive attachment behavior. Bowlby also found that there were individual differences in a child's susceptibility to this fear of separation and loss. This was because of differences among children in: (a) constitutional variables of the child (developmental, invulnerability/vulnerability factors); (b) any previous experiences (i.e., habituation, observational learning) that reduce the child's susceptibility to fear; and (c) any previous experiences (i.e., frightening experiences, stories heard, and threats) that increase the child's susceptibility to fear.

Bowlby (1980) examined children's reactions to separation and loss and its impact upon the development of attachment:

> Since the goal of attachment behavior is to maintain an affectional bond, any

> situation that seems to be endangering the bond elicits actions designed to preserve it; and the greater the danger of loss appears to be the more intense and varied are the actions elicited to prevent it. (p. 42)

He describes this as a developmental process that leads a young child to respond with fear and anxiety when he or she finds, or believes his or her attachment figure to be inaccessible. The actual loss/separation experience causes sorrow and arouses anger which may serve both functional and dysfunctional purposes (Bowlby, 1973).

Bowlby (1973) describes several other responses of children to separation experiences: (a) feeling alone and miserable; (b) feeling sorry for his or her parents; (c) feeling he or she doesn't care what happens; (d) feeling he or she will do his or her best to get along; (e) feeling angry at somebody; (f) feeling that if he or she had been a good child, this wouldn't have happened; (g) feeling that his or her house will now be a scary place to live in; and (h) feeling that it is not really happening, that it is a dream.

Bowlby (1973) highlighted that children's responses to separation differed. Children from "stable" homes expressed more concern and distress at what was happening (attachment behavior); whereas children who had experienced long or repeated separations gave more angry and fault finding responses (withdrawal behavior). Bowlby (1980) believes children separated from attachment figures exist in situations of chronic acute stress where their efforts to restore affectional bonds are continually renewed and frustrated thus reviving feelings of grief and loss.

In his third volume, Loss: Sadness and Depression (1980), Bowlby explores the

trauma of loss. The "loss of a loved person is one of the most intensely painful experiences any human being can suffer"(p. 71). He identifies many concepts of the loss experience which contribute to an understanding of loss for children. Some of these include: (a) affectional bonds between child and parent; (b) grief and mourning experienced by children; (c) a child's use of defenses; (d) experiencing trauma; and (e) the impact of loss upon sensitive periods in early life. Bowlby's research highlights "the long duration of grief, on the difficulties of recovering from its effects, and on the adverse consequences for personality functioning that loss so often brings" (1980, p. 8).

As with separation experiences, Bowlby suggests that there is an individuality of the responses to loss among children. Bowlby believes a child's responses to loss are "greatly influenced by conditions [existing] in his [or her] family at the time of and after the loss" (1980, p. 36). Children will experience loss uniquely and this experience will be influenced by the child's developmental stage, the nature of the loss to the child, and the differing circumstances and contexts for each child.

Bowlby (1973, 1980) identifies three phases of separation and loss responses in children, which he labels as the Stages of Mourning: (a) Protest, where children experience separation anxiety when attachment behaviors are begun but cannot be shut off or stopped; (b) Despair, in which grief and mourning are begun when attachment behaviors fail in making the attachment figure available; and (c) Denial or detachment, in which the child has a need to employ defenses and withdrawal behaviors.

Bowlby (1980) suggests that healthy grieving has several characteristics that were

once though to be pathological. He uses the term "mourning" to cover a variety of reactions to loss and defines healthy mourning as:

> The successful effort of an individual to accept both that a change has occurred in his [or her] external world and that he [or she] is required to make corresponding changes in his [or her] internal, representational world and to reorganize and perhaps to reorient his [or her] attachment behavior accordingly. (p. 18)

Healthy mourning involves coping with pain and experiencing feelings of anger and hatred. Bowlby (1980) highlights the role of anger and hatred in mourning:

> The loss of a loved person gives rise not only to an intense desire for reunion but to anger at his departure and later, usually to some degree of detachment; it gives rise not only for a cry for help, but sometimes also to a rejection of those who respond. (p. 31)

The unavoidable painfulness of mourning is because of the persistent and insatiable yearning for the lost figure. Pain following loss is the result of a sense of guilt and a fear of retaliation (Bowlby, 1980).

The experiences of separation and loss for children entering agency care

Attachment, separation and loss theories have many significant implications for child welfare practice. Separation in child welfare is either actual (temporary or permanent) or threatened (impending) (Siu & Hogan, 1989). Child welfare practitioners need to understand the impacts that separation and loss can have upon a child at different

developmental levels. "Most foster children carry a permanent emotional scar from their separations" (Rosenfeld et al., 1997, p. 454). This knowledge and experience become critical to the decision making process of whether to apprehend a child and to how to support the child through the process of separation and loss. This understanding has also encouraged the development of alternative interventions to the removal of a child from his or her birth family in child protection work (Hegar, 1988; Palmer, 1995).

Siu and Hogan describe apprehension as a critical transition in a child's life. The apprehension represents a "hazardous life event(s)[for the child and his or her family] and customary ways of coping simply are inadequate" (Siu & Hogan, 1989, p. 343). Apprehension represents a crisis for the child for several reasons:

1. An apprehension introduces the experience of separation which will create relationship difficulties for the child and the family. "Once children enter care, existing problems in attachment only increase" (Bayless, 1990, p. 20) because of the potentially traumatic experience of separation, and the resulting relationship difficulties for the child with issues of trust and security. An apprehension cannot be undone, although its impacts can be reduced.

2. An apprehension can be hazardous for the child because the resources for the placement of children are insufficient and often result in poor placement decisions, breakdowns, subsequent moves, and introduces the risk of placement drift and children becoming " in limbo". The Sparrow Lake Alliance Task force (1996) and Steinhauer (1991) document the emotional and psychological impacts resulting for children when drift

occurs. These include: (a) children experiencing intense stress, (b) a child's emotional resources being spent in coping, (c) the child's sense of security being undermined, (d) children lacking significant attachments necessary for psychological and emotional growth, (e) children having behavioral difficulties, (f) children lacking a sense of identity; (g) children having impaired social interactions due to poor self concept, and (h) children becoming detached individuals.

3. Foster care is legally impermanent. Usually foster families are temporary and children can move from family to family. Children understand this, or experience it, and feel insecure. "The longer a child is in foster care, the more placements the child is likely to have, and the more emotional damage the child may have as a result" (Melina, 1997, p. 2).

4. Placement into a foster home also can expose the child to other risks associated with that particular foster family. Children have been subjected to abuse and neglect while being in "protective" custody.

5. An apprehension is hazardous to the child's remaining connected to his or her birth family. Millhan, Bullock, Hosie and Hoak (1986) found that unless a child leaves care within the first six weeks, he or she has a strong chance of being in care two years later. Their study found a marked decline in social work activity on behalf of the natural family by the second half of the first year.

The reasons for a child entering foster care are many, and may involve aspects of the following "scenarios" that I have observed. An apprehension might be sudden and

without warning for the child, or it may be planned and prepared. Children may or may not observe their parents "fighting" for them. A child may be apprehended from a safe place, i.e., school or day care, to reduce the potential for conflict. The apprehension may be the punishment their parents have threatened them with, e.g., "don't tell or you'll be taken away; behave or I will send you to a foster home". However a child comes into care, he or she will experience the separation from natural parents in light of his or her own context and circumstances. Thus, the impacts and consequences will vary from child to child (James, 1989).

Children can be traumatized when they are apprehended and placed in care (Littner, 1967). Trauma can be understood to refer to "overwhelming, uncontrollable experiences that psychologically impact [children] by creating in them feelings of helplessness, vulnerability, loss of safety, and loss of control" (James, 1989, p. 1).

Fahlberg (1988) and Palmer (1995) suggest that there are several factors which influence the child's reaction to separation when coming into care and how traumatic the experience will be for the child. These include: (a) prior factors (e.g., the family environment from which the child is removed, child variables including age and stage of development, and the nature of the attachment relationship from which the child is being separated); (b) experience (e.g., the circumstances of the apprehension itself, the child's perception of the apprehension, the degree of change the child must cope with, the loss of a cultural identity connection, the number and duration of previous separations and losses, and the extent to which the parent(s) prepare a child for this experience including the

child's perceptions of the reasons for the separation); and (c) the extent to which the child welfare system (policies and practices) and the foster family support the child around the experience of coming into care. "Separating a child from his or her parents can have harmful effects upon the child's development. The more traumatic the separation, the more likely there will be significant developmental consequences." (Rycus et al., 1988, p. 4).

Fahlberg (1988) identifies that children will perceive themselves as either being given away, taken away or as being in charge of the move when they are apprehended and placed into care. How the child perceives his or her apprehension will have different psychological and traumatic impacts upon him or her.

Thomlison (1990) highlights the critical influence that post apprehension care and support has in helping the child to cope with the separation experience and the degree of trauma experienced by the child. "The convergence of studies from child welfare, foster care, attachment and child development suggests that successful outcomes of children [in care] are dependent upon whether early negative experiences are continued or ameliorated through later beneficial experiences" (p. 132).

Bayless (1990) and Palmer (1995) identify stages of a child's reaction to placement which are similar to Bowlby's Stages of Mourning (Protest, Despair, Detachment). Bayless (1990) describes five stages of grief for children who enter care and some behaviors which characterize them:

1. Shock: When children first enter care they often are on their best

behavior, called the "honeymoon" period, during which they are often compliant and cooperative. Bayless suggests this may be a result of the child's denial and bargaining coping behavior. Children think that if they are good they may be allowed to return home. Children may develop stress-related illnesses at this stage.

2. Guilt/ Self-Blame: Children who enter care may come to blame themselves and feel being in care is their fault. Often, coming into care, "confirms" for the child his or her negative self worth. Children may be feeling "bad" inside and may act out to be disciplined and punished by their care givers which will validate how they are feeling. Palmer (1995) describes how this self-blame is partially from the child lacking information and understanding about why he or she is in care.

3. Anger: This is often the stage where the behavior of the child may most challenge care givers, as the child does anything to get home. Typically, the child rebels and acts with hostile, defiant, testing behavior. Children may run away during this stage. The child's feelings are often displaced onto foster parents and social workers. The angry behavior may also allow the child to test whether the foster family really cares about him or her. Will the foster family hang in there, or will they discard the child for "bad" behavior?

4. Despair: A sense of hopelessness sets in for the child who now is giving up. Children can experience pain, despair and depression, and their behaviors reflect this. They may be lethargic, withdrawn and regress in their behavior. Physical self-care may deteriorate. Bayless suggests that some children may develop very serious emotional,

behavioral difficulties at this stage including suicidal ideation and eating disorders.

5. Adjustment: In this stage the child begins to invest him or herself in new relationships within the context of being in care. Behaviors are generally more positive and hopeful and children begin to be able to talk more easily about their situation.

McAuley's (1996) research identified that children in care have different feelings and behaviours based upon the length of time they have been in care. Her study compared feelings of children at Stage One (four months into fostering); at Stage Two (one year into fostering); and at Stage Three (two years into fostering). The themes which developed from her study included: (a) the impact on the children of the loss of contact with friends and significant others in their previous homes and schools were greatest in Stage One, (b) there was preoccupation and identification with their birth families at all three stages, (c) the children's perceived a lack of emotional permission for fostering from their birth parents, (d) the children were unable to compartmentalize aspects of their complex social relationships, and (e) the children identified the foster parents as the people in whom they would entrust their concerns at all three stages of placement. Her study did not distinguish between children who were in long term stable foster homes and those who may have had multiple placements.

Fine's (1993) research suggests that children in care cycle through predictable stages characterized by emotional crises with behavioral acting out. These stages involve "an initial honeymoon followed by a crisis of acceptance after two or three months, followed by another period of stability which, after several more months, would lead to a

crisis of belonging followed by relative stability" (Fine, 1993, p. 56). The research data indicates that serious emotional and behavioral crises occurred as the intensity of the relationship between foster child and care givers increased.

Loyalty issues are another factor impacting upon the child's behaviour while in care. Much like a child caught in the middle between separated parents, a child in care may "believe that if he [or she] is accepting of the placement and becomes emotionally close to his [or her] substitute care givers that he [or she] is disloyal to his [or her] birth family" (Fahlberg, 1988, pp. 2-3). As well, any positive feelings displayed by the child towards his or her birth family, may be disloyal to the foster family. The child experiencing this may react with constricted and guarded emotional behaviour.

Palmer (1995) indicates that for children coming into care, their care givers may see the initial protest at the time of apprehension but not often despair or depression. Palmer believes this is because the adults around them encourage children prematurely to detach and they abort the grieving process. Palmer believes this is also a defensive reaction as children may be too overwhelmed by placement and its implications to admit their feelings to consciousness. The importance for practitioners then is the need to come back and help children complete their grieving process. Fahlberg (1988) adds that some children in care grieve for what never was:

> Their grief process...involves grieving for a parent-child relationship which never occurred. Their grief involves not having a parent who was able to love and care for them on a continuous basis. This form of grieving carries just as

> much emotional pain but frequently there is less adult support for this type of grief process. (p. 1)

Bayless (1990) and Palmer (1995) highlight several differences between a child who is experiencing separation and loss because of foster placement (apprehension) and children experiencing other types of separation and loss. These differences affect how he or she copes with the separation and can have significant traumatic impact upon the child. The differences include:

1. Foster placement (apprehension) is usually more traumatic for the child as it involves unfamiliar people (social workers, foster parents, police, etc.) and places (new homes, communities, schools, friends, pets, etc.).

2. The child has usually experienced stressful situations in his or her home before apprehension, i.e., the reasons why the child may have been perceived as in need of protection. This reality for the child has been characterized by a sense of crisis, a loss of control, fear and uncertainty.

3. The child may already have an insecure or anxious attachment relationship with his or her parents because of abuse, neglect, or inconsistent and chaotic care giving experiences. Attachment theory suggests that those children with insecure attachments have more difficulty tolerating separation (Steinhauer, 1995). Children who come into care may not have experienced positive attachments in their families of origin where their basic needs of trust and security may not have been met. Bayless (1990) describes the situation for the child whose basic expression of needs is not responded to

positively, leaving him or her experiencing displeasure, anxiety, and unfulfilled need. These children have learned not to trust relationships, are insecure and fearful, and present the foster carers with behavior that is challenging to cope with and difficult to understand.

4. The children placed usually have lower self esteem because of unreliable, abusive parenting. Children who possess low self esteem may experience doubt about the legitimacy of their feelings and perceive themselves to have little power to change their situation. They experience hopelessness and despair.

5. Children who come into care because of serious abuse are often suffering post traumatic stress disorder.

Palmer (1995) argues that these differences for children entering foster care further push children into prematurely detaching from their feelings about their separation and loss experience, and that "they bury their ambivalent reactions of yearning for and anger towards their parents" (p. 47). These unresolved feelings can prevent the child from placing trust in any relationships with new care givers and affect the child's ability to form new attachments. Bayless (1990), Palmer (1995) and Steinhauer (1980, 1995) believe children who have previously been placed into care and have experienced repeated separations are more vulnerable to traumatic separation experiences because the trauma from separation becomes cumulative.

Palmer's (1995) significant study of the experiences of children in the foster care system and the impacts that system practices can have upon children highlights the reactions of children in foster care to their separation experiences. Palmer concludes from

her study that many social workers, parents and care givers often collude to pretend that separation is not a painful experience for the child. This is often done in a belief they can protect the child from this experience, or it may be denial by the adults in the child's life of their own experiences of separation. Palmer believes that when children in care lack information about the reasons for the separation, they blame themselves. This lack of knowledge leaves the child feeling powerless and creates more obstacles to healthy coping behavior. Fahlberg (1991) suggests that it is critical for care givers and workers to understand those behaviors that children in care develop to survive being in the system.

Palmer believes strongly that children who come into care have the right to receive supports from their social workers, care givers and parents; and that agencies have the responsibility to ensure that these supports are provided. These supports include (1995, p. 136): (a) "Children need to have their separation feelings recognized at an early point; (b) children need to have more information about why they are in care; and (c) children need the opportunity to begin resolving feelings about their families."

Vogrincic (1990) suggests that workers and care givers need to utilize the concept of "transparency" in working and living with a child in care. Transparency involves distinguishing for the child in care the differences between the two families, rather than trying to disguise them. "Clear distinctions between the foster family and the biological family are important for the experience of the child growing up in a foster home" (Vogrincic, 1990, p. 125). This approach supports the child in learning to live and cope with both families by experiencing the differences as real, i.e., values, rules, norms, culture

etc., which allows the child to find his or her place and to test out how it fits for him or her. One helpful way to support children in care to understand this reality is through the use of life books, time lines and placement genograms which provide visual records for the child of life before entering care and since entering care (Vogrincic, 1990).

Palmer stresses the roles that parents, foster carers, and social workers can play in modifying the harmful effects of placement. "All adults in the child's placement must collaborate to provide conditions that will allow the child to experience and express underlying feelings" (1995, p. 50). Natural parents give their children a gift if they can play a role in helping to prepare the child for placement. Social workers need to encourage parents to fulfil this role and involve them in this way during an apprehension process.

The role of the foster parents includes (Palmer, 1995): (a) understanding and accepting the child's behavior as a natural reaction to separation; (b) accepting and allowing for the child to experience the pain of separation; and (c) recognizing that they cannot replace the child's parent or family and in fact need to be able to share the child with their parent through visitation, contact and allowing continuity of the child's natural family to occur.

The primary role of the social worker is to realize that it is never too late for the child to have a full and honest explanation of the reason(s) for the separation from his or her natural family. This would involve workers giving children truthful information, in a developmentally appropriate fashion that included (Palmer, 1995): (a) the reason(s) for

coming into agency care; (b) any information to reduce confusion for the child; (c) any information to reduce the child's experiencing self-blame; and (d) avoiding "socially desirable" explanations.

Social workers need to encourage openness throughout the child's system about the pain of separation and loss:

> Early in foster care, the foster child's feelings about separation are most accessible. If child welfare workers ignore the opportunity to help the child talk about and accept the experience, they lose a critical opportunity to forestall the hazards of denial, fantasy, and repression on the part of the child. (Siu & Hogan, 1989, p. 343)

The child's feelings are accessible if: (a) a child's fear does not overwhelm him or her; (b) the child can trust the person with him or her; and (c) the child can experience validation through the expressing of his or her feelings. Social workers need to develop their skills in accepting and responding to the child's defensiveness and other coping and survival techniques. Social workers who fail to respond to the child's expressed or perceived feelings are belittling the importance of the separation experience for that child.

> Children in care...need an open approach from their workers and care givers, in terms of acknowledging their pain, providing information about their past, and encouraging them to talk about their families. (Palmer, 1995, p. 59)

Chapter Two: Group work with children in care

Rationale for group work intervention

The value of group interventions with children has been well established overall (Fatout, 1996; Malekoff, 1997; Mandell & Damon, 1989; Rose & Edleson, 1987; Siepker & Kandaras, 1985) and specifically with groups of children in care (Mellor & Storer, 1995; Palmer, 1990). "Group work entails the deliberate use of intervention strategies and group processes to accomplish individual, group and community goals using the value base and ethical practice principles of the social work profession" (Toseland & Rivas, 1995, p. 3).

Mandell and Damon (1989) believe that a traumatic experience (which would include coming into care) can disrupt a child's development through the latency-early adolescent stage. Group interventions can enhance the child's social skill development and help him or her to resolve traumatic experiences. The group process combined with appropriate structure and supports assists the child in strengthening impulse control, improving self-esteem, decreasing social isolation and promoting positive social interactions.

Damon and Waterman (1986) identify several goals that can be achieved through group work intervention with children who have experienced trauma. These are: (a) to validate the expression of their various feelings surrounding the traumatic experience; (b) to help children to think about the trauma in ways that are less self destructive to their self-image by helping them to reduce their sense of responsibility and guilt, and to develop

labels for their feelings and experiences; (c) to teach children to be more assertive; (d) to set limits on children's behavior and to help them explore appropriate ways of expressing their needs; and (e) to help children integrate their conflicted feelings surrounding their traumatic experience. Hunter (1990) supports treatment groups for traumatized children citing many benefits, including: (a) reducing a child's sense of isolation; (b) "normalizing" the experience as children will learn they are not the only one; and (c) helping children to dissolve denial and repression as they listen to others' struggles and successes.

Developmentally Sequenced Treatment Approach

Group models of intervention are not able to address all the treatment needs a child may have as he or she matures and develop. In treatment groups for children, a developmentally sequenced treatment approach is often recommended (James, 1989), in which goals and objectives of the group are designed for that particular developmental stage. "Sequenced treatment is necessary because past traumatic events will have different or additional meanings to the child as he [or she] matures, which can impair the progress of development" (James, 1989, p. 5). A developmentally sequenced treatment approach infers that termination of a course of treatment needs to be "open-door," and that further treatment or consultation is available as needed. Information about signs to look for that would indicate this need for further treatment is provided to the child and care giver throughout the program.

Rationale for group work with children in care

Generally, children in care are more likely to present with behavioral, social, educational and emotional problems than children not in care (Colton, Algate, & Heath, 1991; Fanshel et al., 1989; Fanshel, & Shinn, 1978; Jewitt, 1982; Lawder et al., 1986; Pilowsky, 1995; Steinhauer, 1991). The needs stem from both pre-existing factors, which perhaps contributed to the child coming into care, and the overlay of the separation, loss and alternative care experiences for the child. The children coming into the care of child welfare agencies today are presenting with more difficult and complicated needs than previously (Stein, Rae-Grant, Ackland, & Avison, 1994; Steinhauer, 1995).

Palmer's 1995 study of the experiences of children in the foster care system involved a sample of 423 children in the care of two Ontario Children's Aid Societies. Through interviews and videotapes with thirty-six social workers, Palmer identifies eight broad themes which reflect the range of children's reactions to separation and loss experiences. These reactions included: (a) heightened anxiety; (b) behavioral regression; (c) physiological symptoms; (d) increased use of denial and fantasy; (e) persistent attachment to rejecting or unreliable parents; (f) rebellious behavior; (g) delayed expression of feelings; and (h) self-blame regarding being in placement.

Similarly, Lush, Boston and Granger (1991) identified many presenting emotional problems for children in care, some of which can be addressed through a group intervention. These needs included: (a) anxiety, fear of abandonment, and rejection; (b) attachment disorders; (c) anger and frustration; (d) aggressive behaviors; (e) poor

school performance; (f) identity problems; (g) concentration difficulties; (h) poor peer relations; and (i) depression. The child welfare system has a critical need to support the children in care and their care givers through the experiences of apprehension and placement (Palmer, 1990, 1995; Steinhauer, 1980, 1991, 1995).

The emotional and behavioral needs of children in care and the care givers who attempt to meet those needs, overwhelm the child welfare system's ability to meet those needs (Mellor & Storer, 1995; Palmer, 1995; Steinhauer, 1991). Mellor and Storer (1995) state:

> It is apparent that while endeavors are being made to ensure that children's physical, educational, and social needs are well met, and that emotional supports are available, limited resources and lack of training often reduce the possibility of providing the counseling, and therapeutic input demanded by many children in alternative [foster] care. (p. 906)

This reality includes social workers being over burdened by their caseloads and unable or unwilling to experience the emotional pain of working with children in care on separation needs. It has further contributed to the problems of placement drift and breakdowns (Palmer, 1990).

Mellor and Storer (1995) cite several advantages that group work can offer to children in care and their care givers. A group can offer guided therapeutic input to children in care where there is a lack of resources in general to support these children. The child welfare system does not have the resources to provide one on one therapeutic work.

Group interventions can provide opportunities for children to share their experiences of their lives with others who have had similar experiences. This use of peer support and feedback is very important at the latency-early adolescent stage where there can be some resentment by the child towards authority figures who hold some control over his or her life, i.e., social workers and care givers making decisions about visits etc. Through group involvement, children in care can come to an understanding that they are not alone in their current anger and confusion. And, through group involvement, children in care may have an opportunity to develop a support network (Allison & Johnson, 1981).

Palmer's (1990) description of a group treatment program for children in care identified other benefits of a group approach to dealing with separation issues. The goals for the children in her group included: (a) reducing self-blame about being in care; (b) recognizing the many stresses over which they have little or no control; (c) knowing and understanding their life story, in order to try and understand their present feelings and behavior; and (d) through the above, reducing separation conflicts which contribute to placement breakdowns. Separation conflicts were defined as "children's reactions to events surrounding admission to care, their feelings about being in care, and about the partial loss of their biological families" (Palmer, 1990, p. 228). The group was identified as one of the few places where the children who participated felt they could talk about their feelings of being in care. The group also provided an educational function by identifying gaps in the children's information about being in care and providing many opportunities to clarify areas of confusion several of which were common to many

participants of the group. Palmer's group experience identified the need to keep biological families alive to the child.

Rationale for parallel process for care givers

Damon and Waterman (1986) cite the need for care givers to be involved in a parallel process while their children are in group treatment. This process would inform care givers of what their child is working on (i.e., issues identified, emotional reactions to the group and content) and would support the care givers in meeting the emotional needs of their children. In this way, care givers become allies in the treatment. Further, Palmer (1995) suggests foster parents play the critical role in the support that foster children receive in coping with their separation and loss experience. However, it is often the adults in the child's life who struggle with how to support the child after apprehension. Palmer (1995) outlines several training and support needs for foster parents which would contribute to greater support being provided to the child. These include training and education in separation theory, support groups for foster parents and greater recognition and involvement of the foster parent(s) in the case planning for children.

Palmer (1990) highlights this need for foster parents to be involved in the group process for the children in their care. The coping and parenting skills required by the foster parent(s) to support the child's emotional needs will stress their family system. Foster parents can benefit from the support, understanding and direction gained through involvement in a parallel process.

Further, there are the stresses of blending non-related children into an already

existing family structure. The integrating of foster children into a family environment represents changing alliances, hierarchies, and expectations. The family identity can be further stressed by contact with the foster child's biological family which has become an increasing expectation of today's foster families in order to reduce the impact of separation upon the child. Often placement demands on the agency (i.e., visitation, scheduling, transportation etc.) are transferred to the foster family which further interferes with family stability and unity, thus affecting the viability of the foster family system (Steinhauer, 1995). Agencies and social workers must support care givers to cope with these issues in order to prevent placement disruption and breakdown.

Two studies which sought to support foster families in their caring for foster children are the Foster Care Research Project (Steinhauer et al., 1988, 1989) and the Foster/Adoption Systems Training (FAST) Project (Westhues & Cohen, 1987). Both of these studies highlighted the importance of including foster parents in training and support programs which served to increase foster parent satisfaction and improved relations between foster parents and the agency. Steinhauer et al. (1988, 1989) describe the benefits of the Foster Care Research Project which included foster parents: (a) feeling understood through a decrease in their feelings of loneliness, isolation, excessive responsibility and alienation; (b) having the opportunity to ventilate their anger, frustrations and anxieties; (c) feeling supported, by both the group facilitators and other foster parents in the group; (d) gaining some practical relief from other foster parents through the sharing and networking between them; (e) demonstrating an increased

sensitivity to the needs and feelings of the foster children; and (f) reporting an increased motivation and commitment to fostering.

Purposes of group work with children

Toseland and Rivas (1995) outline five types of groups for children each with different goals and purposes. These group types can be combined as the goals and purposes are often complimentary.

1. Support groups are those that employ supportive interventions to assist participants in coping with stressful life events. There is a focus by the facilitator in promoting communication among participants and in developing mutual awareness and support. This group purpose is characterized by the sharing of experiences and coping strategies among participants.

2. Education groups have the primary purpose to help participants to learn more about themselves and their situations through the providing and clarifying of information by the facilitators and between participants. Presentation of information and discussion are the primary modes of communication for this group purpose.

3. Growth groups have a purpose of providing opportunities for participants to gain awareness and understanding of their thoughts, feelings and behaviors. Individual group members may change their attitudes, values and beliefs as a result of this group experience. The focus in this type of group can move between individual or group.

4. Therapy groups seek to help participants change their behaviour which has been defined as problematic, and/or to cope with and ameliorate personal problems

through focusing upon participants' problems and concerns. Individual participants can have different treatment goals which are identified through an intake, assessment process or are identified during the group. The facilitator takes on the role of expert in leading a therapy group.

5. Socialization groups seek to help participants to "learn social skills and socially acceptable behaviour patterns so they can function effectively in the community" (Toseland & Rivas, 1995, p. 27). There is usually more emphasis upon activity for socialization groups than discussion. The group and its activity become the medium through which socialization of participants can occur.

Group Development and Group Dynamics

Facilitators need to have an understanding of how groups for latency and early adolescent aged children evolve and develop. Toseland and Rivas (1995) describe group development occurring through a four stage model comprised of (a) Planning, (b) Beginning, (c) Working, and (d) Ending stages. Mandell and Damon (1989) outline three phases of group development in their model of group treatment: (a) Phase One deals with the beginning stages of group development, and creating a safe and supportive environment; (b) Phase Two explores the trauma experience; and (c) Phase three helps to integrate the group experience and prepare for termination.

Siepker and Kandaras (1985) outline a six-stage model of group development that is distinctive in its focus upon children's treatment groups. Their stage model includes:

1. The Preparation stage, during which the facilitator considers and

addresses many issues and challenges in pulling a group together and begins to develop initial relationships with participants.

2. The Exploration stage, lasting from the first session up to the point where the group has developed an identity and a sense of becoming a "group."

3. The Anxiety stage, which involves each participant struggling with his or her commitment to the group processes.

4. The Cohesion stage, in which members experience a psychological connection to each other and the group.

5. The Termination stage, during which group members recognize the group is ending.

6. The Closure stage, in which the facilitator addresses further treatment needs for individual children (i.e., referral and follow up as required). Also, the facilitators need to reflect upon their own experience in the group and their feelings regarding the group's end and toward individual children.

Toseland and Rivas (1995) believe it is fundamental that facilitators understand groups as social systems. An understanding and appropriate use of group dynamics by group facilitators can promote the goals and objectives of the group. Group dynamics refer to "the forces that result from the interactions of group members...which influence behaviors of both individual group members as well as the group as a whole" (Toseland & Rivas, 1995, p. 69). Group dynamics are a major focus of the group facilitator as they have the potential for both positive and negative impacts upon the group process and the

achievement of group and individual goals. Group dynamics change and evolve through the group development stages described above.

Toseland and Rivas (1995) identify four main components of group dynamics that the facilitators need to understand:

1) Communication and interaction patterns occurring in the group. Different interaction patterns will exist throughout the stages of the group. Verbal and non-verbal communication will influence these interactions. Interaction patterns will be affected by concepts of power and status of participants in the group, size of the group, physical arrangements of the setting, subgroups, and emotional bonds between participants. Facilitators need to be observant of the interaction patterns and to influence them appropriately to facilitate group objectives.

2) Group cohesiveness, which is the degree to which participants feel connected to and are supportive of the group's purpose. Cohesive groups usually have a positive impact on group task accomplishment. Malekoff (1984) provides a four-point framework that facilitators can use to socialize the early adolescent into the group culture over the stages of group development and to promote group cohesion:

A) Discovering the group process which involves exploring what brings the participants together and what directs them as a "group". It is helpful to identify and share participants' past group experiences and to use those experiences and educate through them. For example, each of the participants may be helped to realize that they are all part of some groups already and expand on this idea by looking at what the

purposes of those groups are. This can then be connected to the current group also having a purpose which Malekoff suggests the group can identify together. Having a purpose is essential to group formation. It is important to recognize that the theme of every purpose is mutuality. Facilitators should seek collaboration and cooperation in this process of discovering the purpose together.

B) Searching for the common ground. It is normal human behavior that people try to find a common ground when interacting with strangers. Facilitators need to encourage the participants to explore what connects them as a group. Malekoff (1984) provides some examples for facilitators to try, such as: (a) identifying mutual feelings upon entering the group; (b) promoting the sharing of outside interests which starts the cultivating of the experience of actually being listened to and the enjoyment of being part of a discussion; (c) exploring the emergence of interpersonal styles; (d) developing the group name; and (e) developing group rules.

C) The promotion of playfulness. A crucial factor in the development of relatedness to another is the creation of the playful feeling. This instils a growing connection among the group members.

D) The establishment of group rituals. Facilitators will increase cohesiveness and the group's distinctiveness through participants' identification with repeated "ceremonial" activities, i.e., check ins, problem of the day, having a snack, etc.

3) Social control exerted in the group. Social control refers to ways that a group obtains compliance and conformity from the participants in order to be able to

function. There is always a need for some social control in a group setting, minimally for safety and security. Facilitators strive for a balance between over and under control; the balance being defined by the needs of the participants and the goals and objectives of the group.

Concepts of resistance, norms, roles and status are central to social control. Hurley (1984) suggests that there are blatant and direct types of resistance that children employ to avoid the explorations of inner conflict and interpersonal tensions. The facilitators need to appreciate what role resistance plays in the overall development of the group. Hurley outlines three roles that resistance serves during the three phases of group development.

A) Resistance in the service of defining group structure. In the beginning stage the purpose of resistance by participants is to test limits, provoke a leadership response and to define issues of distance/closeness; trust/mistrust, control, safety, etc.

B) Resistance employed to regulate group tensions. At the work stage, resistance serves as a pressure valve in regulating emotional material in the work/resistance cycle.

C) Resistance used to deal with separation and termination. At the ending stage, participants may present with regressive behavior which seeks to prolong the group and avoid dealing with issues of separation.

The treatment implications concerning the role(s) that participants' resistance may

play and therapeutic interventions for the facilitators include (Hurley, 1984): (a) adopting a posture that he or she is not asking individuals to change but expects the group to change; (b) accepting resistance and redefining it as the participant's contribution to the development of the group; (c) reframing with a positive connotation, i.e., all this conflict helps the participants sort out how they should handle conflict in the group; (d) restraining, i.e., discourage participants rushing in and spilling their feelings until people know each other; and (e) prescribing, i.e., continue what they are already doing.

4) The cultures that develop in the group. Culture refers to the values, beliefs, customs and traditions held in common by group participants. Pfeifer (1992) presents a model which perceives treatment groups as composed of two complimentary cultures: the indigenous peer culture and the therapeutic group culture. Facilitators have to be sensitive to the peer culture that exists and use it in supporting the therapeutic group culture to achieve the goals and objectives of the treatment program.

Group work with children

Selection and preparation for group

There is a need to give attention to the selection and preparation for group participation which involves pre-screening of children and care givers. Several general factors would preclude participation in the program. These essentially would include any reasons that would make the individual a risk to others in the group, or would take away from the group (i.e., psychotic, inability to talk, etc.). Mandell and Damon (1989) also discuss the need for facilitators to continually reassess an individual or family's

participation in the ongoing group. They advocate for two or three individual sessions to prepare the child for group. These sessions would help to address the child's and care giver's anxiety about going to group, and would explain the structure, format and rules of the group. They also suggest contracting with both the child and the care giver around the expectations of their group participation.

Size of group

Hargrave and Hargrave (1983) suggest an ideal children's group size as between six and eight members. It would be unmanageable to have more then eight members in the group. There is a need to resist combining too many age and developmental levels just to get a group going. There can be a considerable developmental difference between an eight-year-old male and a twelve-year-old female. Different developmental levels bring in too many factors for the group facilitators to cope with resulting in too much energy being directed at social control and group maintenance needs. This number also protects against attrition of group members.

Length of group, number of sessions and format of the group

O'Conner (1991) recommends that groups meet minimally once a week for younger children to provide stability and continuity. He advocates for time-limited groups which allow for all participants to start and finish as a group. This eases both the initial warm up process and termination stages of group development. Closed groups are preferable for the same reason, adding or losing participants to a group is very disruptive to the group process. The group being closed allows for maximum group cohesiveness.

In my own experience of doing group work, the ideal length of each session was about 90 minutes long, any longer than this was intolerable. The groups I co-facilitated were time limited groups with twelve weeks being the norm. In my experience, more than this number of sessions would not be realistic as few client systems could commit to that degree of participation (i.e., care givers not able or willing to commit the time or children having other interests). Also, there is the potential for the group experience to become "pathogenic" for the participants if the group seems to go on forever. As well, from an agency perspective, this could represent a significant investment of resources.

Gender issues

Mandell and Damon (1989) advocate for same-gender groups at the latency developmental level. They suggest that same gender groupings result in less over stimulation and distraction, and promote the development of intimacy with same sex peer groups. They relate their comments to treatment groups for sexually abused children in which issues of sexuality and gender identity are often the focus of the treatment work. Further, there is support for having as homogenous a group as possible when providing sexual abuse treatment (Lanktree, 1994). Factors to consider include, gender, developmental stages, and even type of abuse experienced.

Garland and West (1984) explore the issue of group gender composition in relation to age-differences. They suggest that group purpose and goals are the critical variables in selecting gender composition. They report a preference in social group work for same sex groupings particularly for latency aged children and young adolescents.

Theoretically they support this for latency and early adolescent age groupings when "dealing with feelings about issues of gender identity, sexuality, and parents, [which] is often better accomplished in the absence of figures who exemplify these relational states - especially persons of the opposite sex" (p. 61). The dynamics which are introduced in mixing gender groups can have a major impact upon a treatment group. Participants may be at different levels of sexual development. The wider the developmental levels of the participants, the more "crowd control" becomes the primary activity of the facilitator.

One has to balance the benefits of mixing gender groupings with the risks and complications. For a treatment group to help children resolve issues of separation and loss resulting from coming into agency care, I believe there are more benefits than risks to mixing genders. Primary goals include supporting children in developing problem solving and social skills which can best be done when realistic conditions exist, including when both genders are present. Mellor and Storer (1995) and Palmer (1990) support mixed gender groupings for treatment groups specifically aimed at helping children resolve separation and loss issues when coming into agency care. Siepker and Kandaras (1985) suggest that mixed-gender groups can be successfully accomplished in latency and early-adolescence. The primary considerations of forming a group are maturity, social adjustment, school age and developmental levels of the participants.

Co-facilitation

Therapeutic considerations should be the deciding factor in choosing to do co-facilitation in group work. Advantages of using a co-facilitation approach include

(Siepker & Kandaras, 1985; Toseland & Rivas, 1995): (a) two facilitators simulating a family environment (if mixed gender); (b) co-facilitation offers two observations, perspectives, and expertise for feedback, consultation and professional development; (c) co-facilitation allows for splitting techniques as an intervention (i.e., support and confrontation); (d) co-facilitators can complement each other's strengths and weaknesses; and (e) effective co-facilitators can role model for the children social skills such as problem solving, collaboration and conflict resolution. Another distinct advantage of using co-facilitation in group work with children concerns "crowd control" and limit setting. There can be less anxiety for the facilitators and subsequently, the group participants when two persons are setting limits. When difficulties arise, one facilitator can stay with the group while the other can deal with an individual.

Another concern involves safety. If the group is comprised of both genders, then it is important to have both a male and female co-facilitator which provides for safer supervision. This is particularly relevant when facilitating a group of children, some of whom have been victims of sexual abuse. Having a mixed gender co-facilitation team also allows for participants to have both genders to interact with and relate to in the role of group facilitator.

Disadvantages of using co-facilitators involve the time and energy required to work out and coordinate the many issues of the co-facilitator relationship. These include issues of equality and mutuality between the co-facilitators. "Conflict between co-[facilitators] can have detrimental effects on the outcome of the group" (Toseland &

Rivas, 1995, p. 137). How the co-facilitators function as a team and model interaction patterns for the participants can have a significant impact upon the functioning of the group and the achievement of group goals. There is also more time and collaboration required to plan and coordinate the group.

Roles of the facilitators

When doing group work with children, the facilitator needs to consider his or her own "fit" in working with children. Whoever works with this age group has to be able to establish a sense of security and safety for group participants, yet can develop a cohesiveness and comfort level to help the children to be able to share with each other. Siepker and Kandaras (1985) identify certain qualities facilitators require when working with children. These include: (a) a clear acceptance of children as people deserving the facilitator's respect and courtesy; (b) that the facilitator truly likes children; (c) that he or she can empathize with children through verbal and nonverbal communication; and (d) that although liking children, the facilitator does not have a strong need to be liked by children.

Thinking about group leadership involves planning the use of self. "If the worker can playfully accept the kaleidoscopic nature of the pre-adolescent group, the confusion will eventually be transformed into fusion (or it won't)" (Malekoff, 1984, p. 17). The type of group being considered, its purpose, goals and objectives, are important to considering the facilitator roles and leadership styles required.

Structure and limit setting

Mandell and Damon (1989) argue strongly for taking a structured, directive and focused approach to group treatment. Depending upon the specific issues the group is focused upon, most latency-early adolescent aged children are going to have difficulty sharing their feelings about their traumatization. A nondirective approach has the potential to allow for long, uncomfortable silences, creating feelings of insecurity and shame. These are some emotions that latency-early adolescent age children in care are already struggling with.

Malekoff (1984) refers to group facilitators needing to find the balance between tolerance and over control in their work with children. Facilitators need to ensure there is enough structure and direction which provides (Mandell & Damon, 1989): (a) security and safety; (b) clarifies expectations; (c) ensures facilitators cover all significant aspects; (d) allows for sequencing that permits readiness for the material; (e) allows for activities that lead to an increased sense of mastery; and (f) provides direction to the parallel care givers' group.

The use of play as a method in groups for children

Play activities can play an important function in working with children's groups (Rose & Edelson, 1987). O'Conner (1991) suggests that activity-oriented group therapy is ideally suited for latency and early adolescent aged children. The purpose in using play as part of a group intervention is to promote "the development of the child's ability to play, to engage in behavior that is fun, intrinsically complete, person-oriented, variable and

flexible, non-instrumental, and characterized by a natural flow" (p. 345).

The use of play can help to meet several needs that children bring to the group when they may be feeling different, anxious, scared and alone. The value of using play as a method in working with groups of children starts with the belief that play is a child's natural way of expressing him or herself. Using play as a method can help facilitate communication as children are often unable to express their feelings in words. The activity of play releases emotional tension as it allows the child to expend energy, and this relaxation of tension permits the child to express his or her feelings and emotions. Play also allows a child to gain mastery of situations.

Play contributes to meeting the following goals of children's group treatment (Mandell & Damon, 1989): (a) improving socialization by encouraging healthy interaction with peers; (b) teaching children to respect themselves and others through maintaining appropriate boundaries; (c) helping to organize drives into socially acceptable behaviors; (d) strengthening impulse control and reality testing; and (e) improving self-esteem. All of these goals promote the development of social skills.

Play and the use of games helps to build group cohesiveness through promoting fun. Having fun helps to make the group experience more enjoyable, especially when working with difficult, emotional material. Play promotes social interaction and by that assists in decreasing isolation among the participants. Playful activity also provides safe opportunities for the discharge of emotional energy. In treatment groups for children involved with sensitive emotional subjects, participants may need the opportunity to let

loose, yell, be carefree for a while. "As the child feels freer to reveal himself and his emotions, thoughts and opinions, as he knows that he will find support and connection with the therapist and the other children, he will grow stronger within himself" (Oaklander, 1978, p. 290).

Play can help promote the facilitators' relationship with the child and the social interaction and connections between members of the group through the mutual sharing of fun and excitement. Play also brings fun and enjoyment into the treatment group which can help to make the difficult, painful work more tolerable for the child. It helps to relieve intensity. In this way, play helps to alleviate resistance, passivity and avoidance in children.

To achieve these goals through play activities, facilitators need to select games and activities which: (a) are fun, simple and safe; (b) do not require many rules or materials; (c) are such that everyone gets to experience being leader and follower; (d) are non-threatening and all can participate as no special skills or abilities are required; (e) are structured so that everyone can experience success; and (f) allow the facilitators to be part of the play.

A key component of effective play in a group is the approach of the facilitator. "It is very unlikely that any play therapy you conduct will be effective unless you have learned to engage in such play behavior for yourself" (O'Conner, 1991, p. 345). It is very important that the facilitator participate wholeheartedly and be part of the group so that the members can see the facilitator having fun and being "equal" with them. This way of

interacting helps connect the facilitator to the participants by showing his or her humanness as well.

As the facilitator, what you need is: (a) enthusiasm and energy; the play can be energizing in itself; (b) an area where participants can run around, make noise safely without inhibition; (c) not many materials, keep it simple; and (d) some structure and limits to provide safety and security, yet being open, flexible and creative.

There is often a rationale for placing a fun, physical activity towards the end of the session. It gives the children something to look forward to and motivates them to work through the content of the group session. Often the content and material will be upsetting and will generate emotional energy. Having an activity to discharge this emotional energy safely is helpful before the children leave to return home. It also allows a co-facilitator to debrief with a participant if necessary.

Group facilitators need to be sensitive to the dynamics occurring during the play. They need to be alert to and aware of each child and his or her reactions to the play experience. It is useful to discuss and debrief the play/game experience to highlight certain themes, such as: (a) the value of different problem solving approaches, (b) roles taken or prescribed by participants, and (c) the use of different communication processes. In debriefing, the facilitator will help to enhance awareness, promote responsibility and teach listening skills to participants.

Conclusion

It is clear that the experience of coming into care has profound implications for the child. The experience of separation from and loss of biological parents can be a traumatic experience for a child. The needs of children entering care often overwhelm the skills, abilities and resources of the workers and care givers who are involved in supporting that child's emotional needs. Often, this overwhelming need contributes to a child's placement breaking down and a child being exposed to further trauma of placement drift and limbo.

A group intervention can be supportive to children experiencing such psychological and emotional trauma. Support and understanding can be gained through sharing of experiences with other children in care. Information and clarification can help a child to understand his or her reality in a way that places less self blame and impacts upon his or her self concept. Interaction with other children in care can support a child to understand that he or she is not alone. The building of networks can help support a child to cope with his or her experience. The group experience can be a place where children can talk to other children about their feelings of being in care.

Chapter Three: The Group Intervention Process

The Setting

The setting for the practicum was my place of practice: a rural, not for profit, child and family service agency. This agency I work for was incorporated in 1899 and has enjoyed and promoted a long history of connection and support within the community. The agency's stated purpose is to protect children and strengthen families. There has been a consistent commitment made to the prevention of children from becoming in need of protection through a variety of on-going family support and community development programs and initiatives.

The group was run during the spring and early summer of 1998. The group met after school (4:30- 6:00 pm) at the agency's family resource centre, a community based, family support and counselling centre. There are many examples of this type of group (i.e., children's treatment focused, support, psycho-educational) already having been offered through this resource centre.

Selection of participants

My participant population was latency-early adolescent aged children, ages 8-13, who are wards of the agency. Of the 183 children in the care of the agency at the time of the practicum, 96 (53%) were Permanent wards, approximately 45% were of Aboriginal descent and 57 (31 %) were within the ages of eight and thirteen.

The recruitment of participants for the group was done internally. I approached the senior management staff of the agency to discuss the practicum proposal and solicit

the support of the agency. Several issues and dilemmas were identified at this stage which were incorporated into the practicum design. I met with the various supervisors of the agency to further explain and refine the practicum proposal. I then approached the workers of the children in care.

The purposes and goals of the group were identified and various issues and concerns were discussed. Workers were asked to consider the children in care on their caseloads who would fit the criteria for participation in the group and who could benefit from such an experience. Workers were asked to: (a) consult with their supervisor on the appropriateness of a referral to the group for that particular child; (b) to approach the foster parent(s) to discuss further and determine the foster parents' willingness and agreement to participate; and (c) to approach the child to discuss his or her interest and willingness to participate in the group. A referral form was developed and distributed to all workers (See Appendix A).

The co-facilitator of the group (Caroline Corbin) and I conducted introductory and screening interviews with all referrals including the child and his or her care giver. This process was to help participants to understand the purpose of the group and to have an idea of what to expect, as well as to further assess the appropriateness of the group for that child and his or her care giver. Issues of informed consent, benefits of participation, confidentiality and sharing of information were also addressed within this process.

Inclusion criteria

(A) Legal Status: The group was open to children in the care of the agency either

by Temporary or Permanent Court Order. The group was open to children in care under a Voluntary Placement Agreement (VPA), but none were referred to the group.

(B) Age: Children were within the ages of eight and thirteen years.

(C) Length of Care: Children were likely to remain in care for the duration of the practicum.

(D) Other: The child was experiencing some emotional or behavioral needs resulting from his or her experience of coming into care. The child was willing to participate in the program after learning what his or her participation would mean. The child's worker and care giver were also willing to participate in the practicum after learning what that would mean.

Exclusion Criteria

It was decided that children would be excluded for the following reasons: (a) they were unable to cope with a group format (i.e., unable to follow limits, unable to control impulsive behaviour, etc.); (b) they posed a safety threat to other children because of their behaviour (i.e., violent or abusive); (c) they were unable to tolerate the sharing of emotional content (i.e., either unable to share or unable to listen to others); or (d) they had serious psychological or cognitive impairments which would limit their ability to participate in the group process.

Care giver selection criteria

Care givers (foster parents) were considered eligible if they accepted that children in care require support around the experiences of coming into care. Eligible foster parents

were not threatened by their foster child's involvement in a group which placed a focus upon helping the child to talk about separation from his or her natural family. This included the experience of coming into care and feelings of anger and resentment towards the "system" (which includes foster parents) around this experience. Foster parents needed to be prepared to cope with possible emotional and behavioral issues arising for the child from this intensive focus.

Overview of the children's group

The group ran for ten weeks. The overall purpose was to provide opportunities for children to talk about their separation experiences and of being in care. The group combined aspects of support, education, growth, therapeutic and social groups (Toseland & Rivas, 1995). The specific goals of the group were as follows:

1) To enable group members to discuss and relate their separation and loss experiences to others and to validate the expression of their various feelings surrounding their experience.

2) To help children think about their experience in ways that are less destructive to their self-image by assisting them to reduce their sense of responsibility and guilt about being in care.

3) To enable group members to identify common themes in their life histories and subsequent feelings about their histories.

4) To help group members to recognize that what they were feeling was not unusual for children in their situation.

5) To increase and strengthen the self-esteem of group members.

6) To teach children coping skills to more appropriately express their needs, such as assertiveness, anger management, relaxation, identifying and developing labels for their feelings and past experiences, and problem solving.

Critical themes (Allison & Johnson, 1981) to be explored with the children during the group sessions included:

1) The experience of coming into care.

2) Families, and reasons for coming into care.

3) Feeling different.

4) Mixed feelings towards foster parents/families.

5) Coping with school, teachers, and friends.

6) Reactions toward the system, workers and policies.

Each session lasted approximately ninety minutes and was generally structured with: (a) a snack/check-in at the beginning; (b) approximately thirty minutes of "work" and facilitator content; (c) a play activity; and (d) a debriefing and preparing for the end of the session. The variety of activities included paper and pencil handouts to work through and discuss, co-operative activities (i.e., small group work, games, group pictures), role plays, art activities, and directed storytelling. The planned goals and objectives for each week's session are contained in Appendix B.

Overview of the parallel process for care givers

The goals of the parallel process included:

1. To help the care givers verbalize an understanding of the child's needs related to his or her separation and loss experience.

2. To help the care givers develop specific ways to empathically help the child to meet his or her needs resulting from the separation and loss experience from coming into care.

3. To assist the care givers in identifying ways to encourage and support the child in the grieving process.

Specifically, the parallel process for care givers consisted of the following:

1. Individual interviews occurred with care givers prior to the group beginning. This interview outlined the whole process for the care giver and sought to answer his or her questions and concerns. The expectations upon them as care givers were clarified and their informed consent was obtained.

2. Meeting as a support group on three occasions: (a) around the children's group beginning; (b) mid-way through the ten weeks of the children's group; and (c) at the termination stage of the children's group. The purpose of meeting with care givers as a small group was to facilitate the exchange of information, feelings and support between and among the group facilitators and care givers. It was expected that the experience level of the care givers involved in the process would vary and that this would be a factor in this group's development.

3. As well, there was a constant flow of communication between the foster family and the group facilitators, i.e., a letter was sent home each week with the child that

outlined what was covered that week. This included a section which care givers could respond to, or could identify other issues. Facilitators also met with care givers around arrival and home times for group participants.

Issues and ethical considerations

There were three major areas of ethical and practice issues which I needed to consider and plan for in the practicum:

1. Doing a practicum with children. There was a need to be very sensitive to the child's developmental stage when talking with him or her about participating in the group. There was also the need to consider how to involve the child's whole system, i.e., the child, his or her care giver, his or her worker, siblings, extended family, teacher etc. There was the critical requirement to be sensitive to the current circumstances of the child and any risks of the child experiencing trauma through his or her participation in the group. I also needed to consider how the children were asked to consent to their involvement and to ensure that they perceived their involvement as voluntary. The agency, as legal guardian, was asked to consent on behalf of the children to be involved in the group (See Appendix C).

2. Doing a practicum in your work setting. I had to carefully consider how to approach workers to be involved in this practicum. It was critical to consider my role and relationship to the workers because as an "insider", I had a history with the people who would be involved in the practicum. Also, as a member of senior management, I was part of the system responsible for implementing policies and in

evaluating worker's job performance. There was little reaction by the workers to any perception of their being evaluated. Workers were accustomed to the possibility of "management review" through participation in the practicum as this scenario had occurred in past evaluation projects conducted by management and the board. Workers were primarily focused on whether the group would be beneficial to their child in care. A related issue was that of including cases for which I was responsible as the supervisor. I needed to be open to hearing critical comments about services in cases for which I had a responsibility. I also was carrying the baggage of 12 years which have a strong influence upon my perspectives. I received management and worker support for the practicum because of the perceived relevancy of the focus of the intervention to the needs of the children in care.

3. Working with care givers (foster parents). I needed to have the support and participation of the care givers. I received a mixed reaction from care givers, and many required a great deal of information and clarification on the purposes of the practicum before agreeing to participate. I needed to consider the care givers' perceiving there to be any coercive element to their involvement or non-involvement. A care giver consent form was developed (see Appendix D) which attempted to meet this ethical requirement. During the practicum, lack of participation by care givers in the planned parallel process was a difficult issue to attempt to resolve without there being any coercive pressure on them to comply. In the writing of the practicum report, anonymity and confidentiality for all participants, both children and care givers, had to be ensured.

Evaluation plan

Dimock (1970) suggests that there are three factors which can be measured to evaluate group effectiveness including: (a) changes in participants' behaviour (i.e., symptom reduction); (b) changes in knowledge, sensitivity, attitudes, self-understanding, and skills of participants; and (c) changes in participants as described by other people (parent, care giver, teacher etc.) or through the participants' own self-reports. Morris (1987) has outlined three basic questions of any program evaluation process that if answered or measured would help to evaluate the effectiveness of treatment groups. These include:

1) What do I do and why? (and what don't I do and why?) This is related to the goals and objectives for the group.

2) How do I do it and why? This involves examining the methods used in the group work.

3) How do I know what I am doing is working? This is the plan for evaluation.

Measuring goal attainment can incorporate several perspectives including the parents', the child's, the agency's or social worker's; and the teacher's etc. There may also be a consideration of group level goals and objectives as compared to individual level goals and objectives.

A simple pre and post test design was used to collect information on the effectiveness of this group intervention (McCarnes & Smith, 1979). Three questions were

addressed in the evaluation:

1. Did the group intervention assist the children in coping more effectively with their experiences of loss and separation from coming into the care of the agency? This question was evaluated by measuring whether there were any changes in: (a) the children's behaviors, as measured by the Achenbach Child Behaviour Checklist (CBCL) and the Teacher's Report Form (TRF) (Achenbach, 1991); and (b) the children's self-esteem, as measured by the Piers-Harris Children's Self Concept Scale (Piers, 1984). All measures were completed before the group began and upon completion of the group.

2. Did the group intervention and parallel process for the care givers have any impact upon supporting the care givers in coping with the emotional and behavioral issues of the children they were caring for? This question was evaluated by measuring whether there was any change in the care giver's perceived stress of parenting the foster child and utilized the Parenting Stress Inventory (PSI) (Abidin, 1986). This measure was also administered at the beginning of group and at the conclusion of group.

3. What were the children's experience of participating in this group and did they see it as a useful and helpful method of supporting themselves (and other foster children) in dealing with the issues of coming into agency care? And, what were the experiences of the care givers in their participation in the group? These questions are of a more qualitative nature and were assessed in a series of open-ended questions which attempted to assess the reactions of the children and their care givers to the group intervention. A feedback questionnaire was developed for the care givers (See

Appendix H).

Limitations of the evaluation plan

Assessments of children must be developmentally and contextually sensitive. It is critical to have information about the child's functioning from both the care giver and child. However, there is a major risk of care giver bias (Kazdan, 1992). How the child's behaviour, circumstances and contexts affects the care giver (i.e., the child's circumstances and history of coming into care, positive or negative contact with the biological family, the care giver's working relationship with the social worker and agency, the care giver's experience and expertise, etc.) will have an impact upon his or her perception of the child's behaviour and subsequent accuracy in reporting. This fact necessitates subsequent input from teachers and other observers of the child. Care giver ratings of behaviour also focus upon overt behaviour and may not pick up the hidden problems. An additional influence upon care giver perception is that care givers may find it hard to be objective if they perceive their abilities as a foster family to be under "scrutiny". There are also the risks of utilizing self report measures, including faking good and faking bad responses (Kazdan, 1992).

There are many other influences upon the effectiveness of a group treatment model of intervention for children in care to address experiences of separation and loss (Grigsby, 1994; Lanktree, 1994; Palmer, 1995; Steinhauer, 1991). Some of these include: (a) the reason for the child being in care (i.e., the family and child factors making placement necessary); (b) the child's previous history of being in care including: having had multiple

placements; (c) the length of time that the child been in care; (d) the child's legal status and prospects for reunification with his or her natural family; (e) the child's school performance; (f) whether there is evidence of dysfunctional defenses employed by the child; (g) presence of other siblings in care or not in care; (h) whether the child has been in group care; (i) the number of social workers that the child has had; (j) the frequency and duration of parental and sibling visitation; and (k) the attachment relationship between parent and child. These are all critical variables that impact upon the experience for the child entering care and the subsequent effectiveness of the group intervention. To control and account for all the variables was not possible. Therefore conclusions made about the effectiveness of this model of group treatment are subject to many limitations.

Child Behaviour Checklist (CBCL)

The CBCL is a parents' report that measures social competencies and behaviour problems of children. The initial measure was developed in 1983 by Dr. Thomas M. Achenbach and was created from factor analyses of parents' ratings from 2300 children aged 4 to 16 who had been referred for mental health services. Revised profiles for the CBCL were published in 1991 (Achenbach, 1991). At this time the age range for the CBCL was extended upwards to 18. The revised scales are based on factor analyses of parents' ratings of 4,455 clinically referred children, and normed on 2368 children aged 4 to 18. The CBCL (1991) scoring profile provides raw scores, *T* scores, and percentiles for three competence scales (Activities, Social, and School), Total Competence, eight cross-informant syndromes, and Internalizing, Externalizing, and Total Problems.

The CBCL was developed to obtain parent's reports of their children's competencies and behaviors, but foster carers are appropriate respondents; 5.6 % of the total respondents in the normative sample were foster parents (Mooney, 1986). The CBCL has been used in research involving foster children (Hulsey & White, 1988; McAuley, 1996; Westhues & Cohen, 1987). Care givers rate their child for how true each of the 118 items are now or within the past 6 months using the following scale: 0 = not true (as far as you know); 1 = somewhat or sometimes true; 2 = very true or often true.

The Teacher's Report Form for Ages 5-18 (TRF) was developed to obtain teachers' reports of children's academic performance, adaptive functioning, and behavioral/emotional problems (Achenbach, 1991). Teachers rate the child's academic performance in each subject on a 5-point scale ranging from 1 (far below grade level) to 5 (far above grade level). The TRF has 118 problem items, of which 93 have counterparts on the CBCL. The remaining items concern school behaviors that care givers would not observe, such as difficulty following directions, disturbs other pupils, and disrupts class discipline. Teachers rate the child for how true each item is now or within the past 2 months, using the same 3-point response scale as for the CBCL.

Empirical strength of the CBCL

Temporal stability is high; the CBCL Total Problem score has a one-week test-retest reliability of $r = .93$. The inter-parent agreement was $r = .76$. For the TRF Total Problem score, the test-retest reliability over a mean interval of 15 days was $r = .92$, while

the agreement between pairs of teachers was $r = .60$ (Mooney, 1986).

Administration and interpretation of the CBCL

There are no special qualifications needed for administering these instruments, other than an ability to relate to care givers, and children. The forms are designed to be self administered, require no more than a 5th grade reading level and usually take about 20 minutes to complete. They can also be administered orally to parents or youths whose reading skills are poor. When someone is asked to complete a checklist, it is helpful to explain that the aim is to obtain a picture of the child's behaviour as that respondent (the care giver or teacher) sees it.

All users are cautioned that the measures are designed to provide one source of standardized descriptions of behaviour. "It is important to remember that high scores on a Behaviour Problem Scale do not necessarily correspond to a diagnostic label; the names of these scales merely reflect their composite items" (Mooney, 1986, p. 174). Instead, the user should integrate data obtained from multiple informants, standardized tests, medical and developmental history, and direct observation or interviews to form a comprehensive evaluation of the child. A responsible professional should not label individuals solely on the basis of scale scores from any one data source alone.

Critique of the CBCL

The CBCL is a very practical instrument for the clinician as it is easy to administer and to score, is well normed, is inexpensive, and is not too difficult to interpret. The CBCL does not place onerous requirements upon the respondent.

Empirical strength of the CBCL is impressive. A critique by independent reviewers stated "the Child Behaviour Checklist has earned a place comparable to or above any other standard assessment tool for psychologists and other health and mental health professionals who work with children" (Mooney, 1986, p. 182).

Using care giver reports as the test's key informants has some potential risks. Firstly, it may be difficult for a care giver to be able to accurately estimate his or her child's behaviour based upon the three point scale. Secondly, care giver perceptions of his or her child's behaviors and subsequent reporting of that behaviour will be influenced by that care giver's values and expectations of their child's behaviour. And finally, care giver reports may reflect other aspects of the parental system (e.g., anxiety, depression) than accurate assessments of the child's behaviour.

Users are continually cautioned to use the CBCL as a starting point and not the endpoint of a clinical evaluation (Mooney, 1986). Given that caveat to its use, the CBCL can provide users with useful information which has the "potential to play an important role in understanding the development of clinical problems in children" (Mooney, 1986, p. 182).

Piers-Harris Children's Self Concept Scale

The Piers-Harris Children's Self Concept Scale (Piers, 1984) is a self-report measure which looks at children's feelings about themselves. It measures self-concept of the child in six clusters of items, which include: (a) behaviour, (b) intellectual and school status, (c) physical appearance and attributes, (d) anxiety, (e) popularity; and (f) happiness

and satisfaction. There are 80 items in the measure, developed through an item reduction process, which comprise the six clusters. It is designed for use with children eight to eighteen years of age.

The scales are described as a global measure of satisfaction which is best used in educational and clinical settings. Cosden (1986) indicates the measure is best used as a screening tool for "at risk" individuals, as part of an individual's assessment battery, and as a pre and post test measure in "studies of factors affecting self-esteem and in evaluating the relationship of other factors to self-esteem" (p. 514). The measure has limited use in making specific assessments.

Empirical strength

In terms of reliability, the Piers-Harris scales are reported to have good internal consistency with Alpha coefficients of .90 - .91 and KR20 coefficients of .88 - .93 (Cosden, 1986). The Test-Retest reliability is reported to range from .62 - .96 with retest intervals of a few weeks to six months (Cosden, 1986).

Administration and interpretation

The measure can be done individually or as a small group. Simple verbal instructions are provided by the test administrator. Respondents are asked to answer "yes" or "no" to the 80 items, reflecting whether or not the statement is true most of the time. The measure has a grade three reading level and is written to balance both positive and negative responding. Results of the measure are a total score, the number of items checked in the direction of positive self-esteem, and a profile based upon the six clusters

of items.

Critique of the Piers-Harris Children's Self Concept Scale

The major concern with this measure involves the risks inherent in using self-report measures. Also, the items were normed with a total sample of N= 3692, but these samples were not broad based nor demographically stratified (Cosden, 1986). There is limited generalizability as a result. This sampling design suggests that the use of the scale is as a screening device and not as a diagnostic device.

Parenting Stress Inventory(PSI)

The Parenting Stress Index (PSI) (Abidin, 1986) is a self report measure which seeks to identify the effects of stress upon parenting behaviour. To do this the PSI focuses upon the interaction of child characteristics, parent characteristics and life stress factors. The attempt is to have a measure that assesses the parent-child system and how it is functioning.

The current form (Form 6) involves 101 items and an optional 19 Life Stress items (total of 120 items). These items were generated from literature reviews of research in the areas of infant development, parent-child interaction, attachment, child abuse and neglect, child psychopathology, childbearing practice, and stress. This review was further refined down from a list of 150 items through pilot testing, expert paneling of the items and further field testing.

The normative group for Form 6 (N=534) involved parents and their children who were visiting pediatricians' offices, including parents whose children were experiencing

health and/or behavioral problems. The norms contain data on fathers' stress (N=100) which indicates fathers experiencing less overall stress than the mothers. There are mean profiles developed for several clinical groups, e.g., parents of children with certain medical conditions or disabilities. However, there are no mean profiles developed for foster parents of children in care.

Parents are asked to respond to a 5 point Likert scale, from strongly agree to strongly disagree, to the 120 items. These items comprise three sources of parental stressors: (a) Child Characteristics Domain with 47 items (which has six subscales), (b) Parent Characteristics Domain with 54 items (which includes seven subscales), and (c) Life Stress Domain with 19 items which are optional. Raw scores for the subscales, domain scales and total stress scales are then converted to percentile scores which then allow comparison of the individual parent's score to the normative group.

Empirical strength of the PSI

Content validity was established through the item reduction process described above. Further, Abidin reports on approximately 50 published research studies that demonstrate concurrent, construct, discriminant, predictive and factorial validities for the PSI (Abidin, 1986, pp.18-38).

The author reports an internal reliability coefficient (Alpha) for the Total Stress score on the PSI as .95; and for the subscales as .89 for the Child Domain and .93 for the Parent Domain (Abidin, 1986). The manual details how these Alpha reliabilities were replicated in independent studies.

Temporal stability results are also fairly strong. Test-retest coefficients are reported as .96 for the Total Stress score, .63 for the Child Domain and .91 for the Parent domain indicating good stability of the test results over a one to three month interval (Abidin, 1986).

Administration and interpretation of the PSI

The PSI is easily and quickly administered. The PSI is able to be completed in 20-30 minutes and it requires a fifth grade reading level. The PSI provides a Total Stress score which identifies care giver-child systems which are under stress. This Total Stress score is then considered in relation to the subscales of Child Domain, Parent Domain, and Life Stress to provide a clearer picture of the stress the system is experiencing and perhaps from which sphere the stress is coming from. The PSI takes a raw score and converts it into a percentile score which can be used to compare a sample score to the normative data. For example, a percentile score of 40 on the Total Stress (TS) score would indicate that the respondent's score is equal to or greater than 40% of the subjects in the normative sample.

Critique of the PSI

The validity of using the PSI in assessing a foster parent-foster child system is unclear. The PSI is helpful as a screening tool for the identification of parent-child systems which are over stressed. The PSI is also useful as a diagnostic tool in identifying the sources of stress and contributing to the assessment and planning for treatment interventions (McKinney & Peterson, 1986).

Practicum committee

The practicum committee consisted of advisor, Dr. Diane Hiebert-Murphy, member of the Faculty of Social Work; Professor Kim Clare, the Director of the Winnipeg Education Center, and Nancy Hunter, the Supervisor of Resource Development and Group Care for Child and Family Services of Western Manitoba. The committee met prior to implementation via phone conference to review the practicum proposal and to consolidate the goals of the practicum, and at the end of the practicum to review the practicum.

Practicum supervision

The group sessions were videotaped for use in clinical supervision. On site clinical supervision (Brandon) was provided by Nancy Hunter. Each group session was debriefed and reviewed between the co-facilitators and Nancy. This clinical supervision focused upon the content and process for each session and the identification of specific objectives and plans for the next session. Recording during the practicum included: (a) referral material, consultations and pre-group contacts; (b) session notes (group process and observations); (c) session planning; (d) supervision and consultation notes (debriefing, feedback and planning); and (e) recording for agency purposes on the Child in Care (CIC) file (i.e., summary of child's participation). Supervision notes and copies of the videotapes were sent to Diane Hiebert-Murphy (Winnipeg) to allow for additional clinical supervision via phone consultation. I also was able to meet with Diane approximately every three weeks in Winnipeg to continue clinical supervision in person.

Chapter 4: Practicum Experience and Findings

Overview of the group process

Stage 1 Pregroup planning

Pregroup planning involves all the work and activity up until the first group session occurs. This stage is concerned with "conceptualizing, screening, composing, and balancing the group" (Schnitzer de Neuhaus, 1985, p.58). There were three components: (a) preparation within the agency to establish the group intervention (i.e., discussion with workers, and management); (b) preparation by the group facilitators to become the group leaders, including emotional, intellectual and practical preparation; and (c) preparation with the child and care giver for their participation in the group, including screening, explanation to the child and care giver, and the beginning of developing a trusting relationship.

The Child and Family Services Information System (CFSIS) was used to identify all the children in care (CIC) of the agency who met the age criteria. Workers for these children were then approached, either individually or during unit meetings. It was important that the agency and the workers referring the child understand the value and benefits of group work (Schnitzer de Neuhaus, 1985). In many instances, this was already accepted, as within this setting there have been previous models of group work with children being utilized for different purposes, e.g., anger management, sexual abuse treatment, sexual offender treatment, children in alcoholic families. There was a positive, accepting attitude within the agency towards group interventions.

Meetings were held with workers and supervisors to further clarify the goals and purposes of the group and criteria to consider when referring a child to the group. Materials and information handouts were developed to share with supervisors, case workers, and the care givers.

At the beginning there was a good relationship between the referring workers and the group facilitators, one of trust, comfort and a willingness to work together. The co-facilitator and I previously worked together in the agency when we had provided group treatment programs to children who were victims of sexual abuse. Also, the co-facilitator had expertise and credibility given her role within the agency of working with a CIC caseload.

Of the 57 children in care of the agency who met the age criteria, referrals were received for 15 children. As the group began to coalesce, 11 of these children were at the older end of the age-developmental range for the group, and the remaining four were at the younger end. A decision was made to provide a group for the older cluster of children at this time and not to try and combine too many developmental levels together as has been suggested by Hargrave and Hargrave (1983). Of the 11 children in this grouping, four of the referrals did not proceed past the screening stage for various reasons. One child would be returning home prior to completion of the group; two were assessed, in consultation with their social workers, as not being able to tolerate the group process because of very high social and emotional needs; and one child's foster parent refused to allow the child to participate. The resulting group of seven participants was not selected

in any random fashion, but was fairly representative of the children who were in care of the agency.

There were 42 children who met the age criteria who were not referred to the group. Some were not referred as they did not meet the other criteria for group participation. It would be interesting to know why more children were not referred to the group. Future groups could then be designed to be accessible to more of the agency's children in care (i.e., more inclusive criteria).

This pregroup planning was a critical stage as you are inviting the worker, the child, and the care giver to participate in the group (Siepker & Kandaras, 1985). I found that there was a constant struggle for myself between the need to have enough referrals for the group to proceed and in not being perceived as coercive in any way. There was some resistance by case workers to having a child on their caseload participate in the group; for some it involved having some increased work load (i.e., arranging drivers, discussing with child and care giver etc.). However, overall there was enthusiasm and support for the group from social workers and the agency.

I did approach one worker who had not thought of referring a particular child. I asked her to consider the child's participation, which she agreed to do as she saw the group as benefitting the child after we had discussed it. I was also this worker's supervisor, and I needed to be careful to only provide information to the worker and not to pressure her to have her CIC participate. How she perceived my approach may be all together different.

Meetings with care givers occurred before the meeting with the child as there was a need to secure the care giver's participation and support prior to approaching the child. The child's worker was often part of this process as it was the worker who had a significant and trusting relationship with the care giver(s), and the worker's support and acceptance of the group for the child went a long way in gaining the care giver's participation. At this stage there was again clarification as to what the expectations of the care givers were, including the parallel process as described in the outline provided to care givers (See Appendix E).

There was some resistance encountered with some care givers, while others were eager for their child to participate, seeing it as helpful to the child in coping and hoping for improvements in behaviour. One care giver refused to have her foster child participate. In discussions with the care giver she identified her fear, a fear shared by other care givers, that this program would "stir" things up for the child, behaviour with which she would then have to manage. She was also not convinced of the need for nor the benefits of the child having this opportunity to talk about her separation feelings and the experience of being in care of an agency. Palmer (1995) explains this resistance from care givers as their wanting to avoid the pain and effort of doing the work with children around separation. An unspoken concern was the fear by some care givers that their foster child may say something negative about them as care givers in the group. Palmer (1990) indicates that when children in care are given the opportunity to discuss their fostering experience, a great deal of anger is likely to be expressed. This anger is directed towards workers, care

givers, birth parents and the "system".

This case situation highlighted the tensions that the agency sometimes has in its relationship with care givers (foster parents). There can be a struggle between the agency as "guardian" and the care giver as the "parent" for the child when the agency's values and beliefs about what is best for a child conflict with those of the care giver (e.g., the importance of maintaining family ties through visits, or the child participating in a group to help him or her to cope with his or her feelings about being in care). Much of the support work done with care givers revolves around negotiating these impasses. For the group facilitators, this tension was part of the context in which a trusting relationship between the child participating in the group, his or her care giver and the group facilitators was developed.

Care givers were consistent in avoiding examination of their own issues, feelings and behaviors. This will be described in greater detail later, yet at this initial stage as we met with care givers to discuss expectations etc., they wanted to limit the degree to which they were being asked to look at themselves, and their families. In the desire to get the group started this issue was not fully explored with care givers at this initial stage.

The initial meeting with the child occurred after the screening of written referral information and the meeting with the child's care giver. This was done with the co-facilitator and generally occurred in the child's home. One child was brought to the agency by her care giver, while another was met at his school with his worker. For the three children in rural placements, travel to their community was involved.

This initial meeting involved explaining to the child what the purposes of the group were and what he or she could expect to happen at the group each week. Most of the children's questions revolved around who else would be there (other children who live in foster homes) and what they would have to do in the group (various things; talk, work, play, never forced to talk, etc.). One child asked if her mother would be at the group. This child's question illustrated the critical need for the facilitators to constantly consider and understand the meaning of the group experience from the child's perspective (Schnitzer de Neuhaus, 1985).

Most of the participants were able to identify some enthusiasm towards coming to the group. No child self-selected him/herself out of participating in the group at this point. Often, the care givers were also present during these meetings, and they were very helpful in supporting the child to ask questions, and in clarifying for the child any points of confusion or doubt. For all of the children, it was difficult to think about talking about being in care. For some of the children, feelings related to their care experience and separation from parents were accessed at this initial stage. Some said they didn't want to talk about it; all were assured that they would not be forced to discuss, but that perhaps with the support of others, they may find that they wanted to.

The next step involved contracting with both the child and the care giver on their participation in the group (Mandell & Damon, 1989). This discussion revolved around the mechanics of the group: location, frequency, length, general format of the group, measures to be used, use of videotaping for supervision purposes, and other related issues.

Ground rules for the group interaction were also discussed with the children so that their safety was ensured. We covered what they could expect to happen in group and for the care givers, in the parallel process.

For the three rural children transportation became an issue to be resolved. The agency agreed to cover the expenses of transporting these children to the group on a weekly basis. Drivers had to be arranged for two of the children as their care givers were unable to provide the transportation. This responsibility fell partly on the child's worker. There also had to be some discussion and negotiation with the child's school, as the rural children needed to be pulled out of school early in order to get to group on time. One child had a 1 1/2 hour drive one way. There needed to be some flexibility at this stage, as co-ordinating the lives of seven busy, active children and their foster families in order that they could participate in the group necessitated some give and take.

There was some "selling" to the children and care givers on the potential benefits of participation in the group. Some of the child-care giver systems had been well prepared by their worker, others less so. The relationship between the child, care giver and the worker appeared to be a factor to the child's and care giver's enthusiasm for participation in the group. Most had significant, long standing relationships with their worker, and were easily convinced on the program. For some others, it was less so. The issue of confidentiality for group participants was also addressed, including what information if any would go back to their care provider or social worker. At this stage, informed consent was obtained from each care giver, and on behalf of the children in care, from the guardian

agency. Samples of the informed consents are found in Appendix C and D. All workers, care givers and children understood that this group was part of a master's practicum.

Overview of participants

I am providing some limited, non-identifying information about the participants and their care givers to illustrate to the reader some of the contextual realities for these children and to heighten the understanding of their lives and participation in this group. See Tables 1 and 2 which summarize participant profiles.

One of the children was in a kinship placement with a maternal second cousin. The other six participants were in family foster placements. One of the children had previously been in group care. Of the seven participants, five were Permanent Wards of the agency, the other two were Temporary Wards.

The mean age of the participants at the time of group was 12 years, 8 months of age, with a range of 11 years, 8 months to 13 years, 10 months of age. Four participants were female, three male. Two of the participants were of Aboriginal descent, the others were Caucasian.

The mean age of the children when they first entered care was 6 years, 8 months of age with a range of 6 months of age to 11 years, 6 months of age. The mean number of total placements (defined as distinct foster or group home placements) was 2.8, with a range of 1 to 5 placements. This represents a fair degree of stability in placement for the children in the group.

The mean value for the total length of time in care was 3 years, 11 months, with a

Table 1

Participant Demographic Profiles.

	Age at time of group	Gender	Race	Legal Status	Age at Permanent Order
Child 1	12 yrs/2 mos	Male	C	PW	11 yrs/9mos
Child 2	11 yrs/8 mos	Female	A	PW	1 yrs/2 mos
Child 3	12 yrs/5 mos	Female	A	PW	10 yrs/6 mos
Child 4	13 yrs	Male	C	PW	7 yrs/9 mos
Child 5	12 yrs/2 mos	Female	C	TW	n/a
Child 6	13 yrs/6 mos	Male	C	PW	12 yrs/2 mos
Child 7	13 yrs/10 mos	Female	C	TW	n/a
Mean	12 yrs/8 mos				

Note: C = Caucasian; A = Aboriginal; TW = Temporary Ward; PW = Permanent Ward.

Table 2

Participant Care Experience Profiles.

	Child's age at first admission to care	Total # of foster homes	Total time in care	% of life in care	Total # of workers	Sibs in care	Placed with sibs
Child 1	10 yrs	2	2 yrs	17%	4	yes	no
Child 2	6 mos	3	11 yrs/2 m	96%	7	yes	yes
Child 3	8 yrs/6 mos	2	3 yrs/11 m	31%	3	yes	yes
Child 4	2 yrs/8 mos	5	6 yrs/5 m	49%	1	n/a	n/a
Child 5	11 yrs/10 mos	1	4 mos	3%	1	yes	no
Child 6	6 yrs/4 mos	3	2 yrs	15%	2	no	n/a
Child 7	7 yrs/1 mos	4	1 yr/6 m	11%	2	yes	no
Mean	6 yrs/8 mos	2.8	3 yrs/11 m	31%	2.8		

range of 4 months to 11 years, 2 months. Stated differently, the mean for the percentage of the child's life spent in care was 31 %, with a range of 3 % to 96 %. This represents a wide range in the length of care experiences among the children in the group.

The mean value for stability of relationships with social workers (the total number of different workers since entering care) was 2.8 workers, with a range of 1 to 7 workers. Of the seven participants, one had no siblings, five had siblings who were also in care, and one had a sibling who was not in care. Of the five participants with siblings who were also in care, two were placed with their sibling(s), while three were not placed together with their siblings.

The reasons these children came into care reflect the range of child protection concerns. These included: (a) parental incapacity due to mental health issues; (b) sexual and physical abuse; (c) neglect (poor, insufficient physical and emotional care; multiple and unpredictable care givers, etc.); (d) parental drug and alcohol addiction; and (e) the child's emotional and behavioral needs being beyond the capacity of the care giver to meet. In reviewing the placement histories for these children, all but one had experienced a return to their parent(s) after initially coming into care. The longest period of time remaining with the parent before returning to care was 5 years, 3 months; the shortest was 2 months. One child had experienced two attempts at return to his or her parents' care before becoming a Permanent Ward.

Of the five participants who were Permanent wards, only one had been old enough

to participate in the court process (12 years of age or older), during which the judge asks the child whether he or she understands and agrees with the agency plan. This experience for a child is often overwhelming and not always conducive to the child feeling that he or she has had the opportunity to participate in the planning. Both of the participants who were Temporary wards were old enough to participate in the court process. This became a theme in group as both participants were involved in court processes during their involvement in the group.

Of the seven participants, five had some degree of regular contact with their biological families. Some of this contact was with extended family and/or siblings and not the parent(s). One of the children had participated in a Family Group Conference prior to becoming a Permanent Ward. Family Group Conferencing is a new program initiative in which the extended family of the child is brought together to develop a plan for the child. This process involves reviewing the agency's protection concerns for the child, the expectations on the parent(s) in order for the child to be able to return home, and the extended family's capacity to support the child and his or her family in meeting those expectations. The setting and context of the meeting is supportive to the child. The child has an advocate with him or her who can help the child in stating his or her feelings and wishes.

Overview of care givers

Two of the children reside in the same foster home, so sample size of care givers is six in total. The mean experience level of care givers as licensed foster parents was 5

years, 6 months. The highest experience level was 14 years, 7 months, with the lowest being 4 months. All of the foster parents were Caucasian.

One family was a single parent family while the rest were two parent systems. All the families, except one, had their own children as well as foster children. Three of these families had adult children living outside of the home; the other three families had school or pre-school aged children. One of the families was caring for a school aged relative, while another provided care for a mentally challenged adult.

Only two of the six foster families had previous placements as licensed foster homes. The family who had been fostering for over 14 years, had a total of 18 previous placements for varying lengths of time. A review of their previous placements indicated that many of these children reached the age of majority while living in this home. Therefore, four of the foster families have only provided care for the child who participated in the group. Two of the families had started providing care to their child before they were licensed as foster homes. One was an extended family placement. The other started out as a Place of Safety before becoming licensed as a child specific foster home. Two of the families are providing care to sibling groups, of which, one was participating in the group. Three of the families lived in rural areas. All of the families had attended Foster Parent Orientation courses, but only two had participated in further training opportunities.

Before group started, pretest measures for the care givers (CBCL and PSI) and teachers (TRF) were distributed. The measures for care givers were hand delivered and

some direction and explanation provided. The TRF was mailed out to the teachers with a covering letter (See Appendix F). Other than one exception, the pretest measures were completed and returned in a timely manner. One care giver reacted angrily towards some of the more personal questions contained in the PSI. She refused to complete any of the measures at this point stating she understood the focus of the practicum to be on helping the child and not upon her and her family. I was unable to alleviate her concerns regarding family privacy, suitability of the measure and the focus of the intervention including the coping by the care giver in parenting a child in care. She did not pull the child out of the group, but was no longer involved in any parallel process. This situation was discussed with the referring worker for possible follow up supportive intervention with the care giver and child.

I had not anticipated this reaction to the measures by care givers. In retrospect, more effort should have been made to understand the concerns of care givers prior to their agreeing to participate in the practicum. Greater explanation about the purposes and need for measurement should have been provided. For care givers, this group was offered to them and their foster children through the agency and by an agency staff person. Even though it was clearly stated that this was part of a practicum, their perception could have possibly been that the group was an agency program and expectation. This situation highlighted for me the need to understand how individual care givers perceive the agency and how they themselves define their relationship and role with the agency and toward the child. How closely their perception of their role with a child corresponds to that described

by Palmer (1995) remains an issue to assess in future groups. The care givers' perceptions of their role with the agency and the child has a direct impact upon their willingness to participate in supporting a child with his or her feelings related to being in care and in maintaining family ties (Palmer, 1995).

Stage 2 Group beginnings

Participants and facilitators begin the group with feelings of anxiety and anticipation. Lampel (1985) describes the initial sessions of a group as having a "birthday party feeling" in which participants start to assess each other and the group facilitators to determine where they fit in to the group. There is anxiety because this group is a new experience for them. Who am I here? Who are you? Facilitators also experience anxiety. Can I manage this group of kids? There is the anticipation of what is to come. Is this group worse or better than they had imagined?

This initial stage of the group is focused upon getting to know each other and in the facilitators helping the participants to feel safe and comfortable enough with each other to be able to share feelings about their experiences (Mandel & Damon, 1989). The group was also involved in discovering the group process, and what connected them as a group (Malekoff, 1984). The participants are trying to figure out their place in this group. There is an initial search for connections with the other children in the group and with the facilitators (Lampel, 1985). Two of the participants discovered they knew each other already.

Facilitators need to develop a connection with each child in the group, one of trust

and acceptance, in order to develop the sense of "we-ness" as a group. Lampel (1985) describes how facilitators can accomplish this. Facilitators can show no favoritism and need to be shared with all in the group. Facilitators must demonstrate apparent concern for all the participants. Facilitators need to communicate with all the participants individually, yet develop the "we" that is critical to group development.

For each group session, the facilitators developed a plan that was generally followed. The sessions occurred in a large room with space to be active in. There was also some green space close by which was used on occasion when more space was needed for an activity. We had the center to ourselves on the nights of group so were able to be loud and to move around a bit. We would meet around a group of tables which in the beginning felt too large and classroom like. As well, when doing interview or small group activities we would often break from the table area and spread out on the floor to different corners of the room. Over the duration of the group, we decreased the size of the collection of tables, which allowed for closer contact and interaction between participants. This seemed to happen as the group evolved and became more cohesive.

In the group beginning stage, activities and structures are designed to establish beginning "groupness" and to limit anxiety of participants (Lampel, 1985). An initial activity involved discussing the purpose of the group and looking at how this group was similar or different from other groups the participants were involved with (Malekoff, 1984). It was difficult at this early point to really know if the participants had a clear understanding of why they were coming to this group, as their ability to talk to each other

was limited. The facilitators needed to continually clarify issues and make connections explicit to the overall purpose of the group. In this way the group purpose was an evolving one, and as the participants began to understand and connect its purpose to their own experience, they were able to participate more fully.

A technique of breaking into dyads to complete interview sheets was used as a method of promoting interaction between the participants. The dyads would complete the interview and then return to the larger group to share what their interviewee had reported. It appeared to be less threatening to the participants to share feelings in this fashion. In the large group, similarities and differences between participants were often highlighted and discussed to promote sharing and an understanding of each other's experience. "Does anyone else feel that way?" "Has that ever happened to you?" "Do you understand what he (or she) is trying to say?" In this way, connections between participants' experiences were initiated and group development promoted. At this early stage, the differences between the experiences of the participants was already emerging as a theme of the group, one that facilitators needed to be sensitive towards as opportunities arose for supportive discussion.

An early activity promoted the objective of participants learning from each other. As a group, the participants discovered that between them, they had 28 years of experience of being in care. Facilitators capitalized on this by promoting the participants' expertise in this area and indicating the desire to learn from their experiences. The participants learned that they had many things in common, and were not alone in how they

were feeling. This activity also helped to promote the group identity and start to develop cohesiveness. The participants started to catch on to what the group was all about.

At this early stage of the group development there was some sharing of separation and care experiences. Participants "stuck their toe in the water" by sharing some initial feelings and then gauged the reactions by participants and the facilitators. It was crucial at this early stage that feelings expressed by the participants were accepted and not judged by the facilitators and the other participants (Toseland & Rivas, 1995) in order to promote communication and sharing of feelings. Facilitators need to demonstrate acceptance, patience and understanding to all participants (Lampel, 1985).

Participants did a great deal of testing each other and the facilitators through making comments and statements intended to provoke reactions. This was especially so across gender boundaries. Participants constantly displayed emotions and behaviors of approach and avoidance with the other participants and the facilitators. Lampel (1985) suggests this is the participant's asking the question "Can I trust enough to come back again"? Facilitators try to support the reasons participants have for coming back, and mitigate those reasons participants have to not come back to group.

Facilitators attempted to universalize the experiences and feelings shared by participants through modeling of empathic listening skills. This was to try and initiate some communication between participants and a demonstration of acceptance of each other. It helped to create an inter-dependence and cohesion among the participants. This sharing also helped the participants to develop a mutual identification which created a

supportive feeling within the group. This process allowed for interactions to occur between group participants, even across gender lines. A vivid example of this was one participant crying and her receiving emphatic support from most participants.

The gender of participants played a factor in their forming of dyads and sub groups throughout the duration of the group, but especially in the beginning stage. There was some anxiety, especially from the boys, about being paired with a girl for an activity. At this developmental level, the dynamics and developmental needs associated with gender issues in the group became a focus for the facilitators (Garland & West, 1984). Some of the participants had limited skills in being able to work in small groups. Initially, facilitators spent much of their time and energies in providing limits, supports and structure to these activities so the anxiety felt by participants was decreased and their safety ensured.

The use of play activities was helpful in developing the group's ability to interact with each other. There was an incident early in the group in which one participant was accidentally hurt by another. This provided an opportunity to talk with the participants about respecting themselves and others by playing safe and became a therapeutic intervention with the participants. In this initial stage of the group development, play activities were moved from the end of the session towards the beginning as the members often arrived with a great deal of energy and a need to move. This change illustrated the need for facilitators to be flexible and to match the planning of the group to the needs of the participants.

In the early sessions there was some reaction by the participants to being video taped for supervision purposes. The equipment was always set up ahead of time and was fairly inconspicuous. After some initial horseplay to the cameras, we reviewed the purpose of video taping the sessions and who would see the tapes. The novelty quickly wore off and it became basically forgotten.

A tradition developed in the early stages of group where we would have a check in at the start of each session using the concept of a thermometer to gauge how participants were feeling that day. Malekoff (1984) highlights the development of group rituals as an important method of socializing group participants into the group culture. This use of a check in was an effective method in bringing the realities of the participants' lives into the group process. Often participants used this as an opportunity to "debrief" their day at school. Conflicts and problems were shared which prompted some discussions on problem solving and alternative ways of resolving situations. In this way, all of the participants were able to share and gain support from each other.

Initially, there were examples of some participants playing "can you top this!" or in trying to shock other group participants but this dissipated over time. Hurley (1984) suggests that this may be an attempt by the participants to avoid the exploration of emotional issues and illustrates their anxiety at doing so. This form of participant resistance in the beginning stage helps to promote group process by testing limits and provoking leadership responses (Hurley, 1984). It is also an indication of the poor social skills that some of the participants have developed or is perhaps related to their perception

of the purposes of the group. The key for the facilitators was not to jump to the bait but rather to discuss comments made in a matter of fact fashion, so as not to draw more attention to the behaviour and to provide alternative ways to express those feelings more appropriately. There were times however, when the facilitators were not sure how to respond.

Lampel (1985) suggests that participant behaviour at the beginning stage of group is part of his or her trying to assess where and how he or she fits into the group. "Can you see me?" "Can you hear me?" "Is it okay if I stay here?" "Where do I fit in?" As each child sorts these questions out, the roles and status of participants become identified.

The participants enjoyed hearing from the facilitators about their week at check in time. This seemed to help the connection between the facilitators and the participants. Nutrition snacks accompanied this activity and it became an important part in helping the group to form an identity and developing cohesion. The participants arrived at group after a day at school and were often hungry.

The check in became a simple method to help participants begin to talk about their feelings and to try and help them to elaborate this through gentle, supportive questioning. It was also used to build connections between participants and to fill in the week apart as participants would offer updates from their previous week's sharing.

Participants demonstrated good listening skills with this activity and some of the participants were able to share appropriately with this activity right from the beginning. Others could only give very limited, one or two word responses. On one occasion, a

participant wanted to share too much information too early, and had to be encouraged to "hold back" (or restrained) from doing so (Hurley, 1984). This illustrated some of the differences in social skills and self esteem between group participants. Overall, the quality and depth of sharing during this activity by all participants improved over the duration of the group.

For each session there were lots of paper, pencil crayons and markers available and the participants made good use of them. Some of their use involved directed activity, but most of it was simply doodling while we talked in the group. I have found in previous group work with children that keeping their hands busy and being able to avoid eye contact on occasion facilitates discussion around difficult emotional issues. That was the case in this group as well.

The participants began identifying their own needs and issues as early as the second session. In this session, one of the participants wanted to talk about an upcoming visit with his biological mother. The facilitators began to redirect questions posed by a participant back to the other group participants for their thoughts and reactions. This illustrated the role of the facilitators in promoting interaction and communication among participants and not only having it directed towards the facilitators (Toseland & Rivas, 1995). This interaction between participants started slowly, but as the group evolved and participants became comfortable with each other, more of the exchanges were between participants and not through the facilitators.

The tool of using a journal was introduced in the beginning stage of the group.

The journal was developed to try and consolidate the learning which occurred in the group, much like the Resolution Scrapbook (Lowenstein, 1995). Participants could take the journals home between sessions to work on them or to show them to their foster parents if they wished. The journal was theirs to have on completion of the group.

Towards the end of each session the participants worked on an "Exit Slip" (See Appendix G) which was developed to focus and summarize what happened during that session. Again, the quality and depth of the completion of the exit slips varied between the participants but did show an improvement over the duration of the group. These exit slips were then collated into the child's journal along with any art work, activity sheets or group developed charts and word splashes. At the bottom of the exit slip was a space where the participants could direct a question or concern to the facilitators that they were not ready to share in group. During the time between group sessions, the facilitators would meet and respond to any participant inquiries. This was also an opportunity to provide to the participants further feedback on their participation in the group. This became a meaningful way to communicate between the facilitators and some of the participants as they appeared eager to read the response from the facilitators at the beginning of the next session.

On occasion a question would be raised in an Exit slip that had relevance to the whole group. That participant was then approached to see if he or she would be comfortable with the facilitators raising it in the group session. An example of this was one participant who recalled some frightening memories of when she came into care. She

agreed to having that shared with the group and it became a catalyst for looking at the feelings around coming into care for the other participants. "Individual goals become group goals as participants begin to verbalize their desire for change" (Lampel, 1985, p.107). In this way, the content of the group sessions took on some of the goals and needs of the participants, goals which they had not been able to identify at the beginning of the group.

There were a few situations where facilitators sought a child's permission to share relevant feelings expressed by the child in the group to his or her care giver and or worker (e.g., fears over the court process, desire to have contact with birth family, desire to have some clarification). Participants were often encouraged and supported to take an issue home to discuss with their care givers or workers.

The play activities themselves did not always go smoothly in the beginning stage of group. For some participants, there was not enough physical activity involved and activities had to be adjusted to be more "athletic". Some activities involving touch (e.g., the Human Knot) had to be changed as the group had not yet reached that level of comfort and trust with each other yet at the beginning stage. For this group, gender issues were a significant "regulator" of the participants' willingness to interact with each other. Yet, this promotion of playfulness (Malekoff, 1984) was very important to the development of group cohesiveness.

Towards the end of the beginning stage of group, the facilitators started to see some natural connections developing between participants. This was often observed

outside of group, i.e., waiting for rides home and planning to talk on the phone. The participants had caught on to what was supposed to happen in group and had started to label it as their group. This marked the transition to the middle phase of group development.

Stage 3 Working phase

It was apparent to the facilitators by the fourth session that the participants knew the purpose of the group, had started to sort out some of the issues about how they fit into the group, and had started thinking about how the group could work for them. As the group evolved there was greater sharing, acceptance and recognition of participants' feelings of loss, pain and anger. Most of the participants felt safe and trusting enough with each other to express their emotions more openly. Seating arrangements started to change as there became greater interaction among group participants. This was not universal among all participants but the quality and intensity of discussion did develop through this middle working phase of the group's development.

Of interest were the different needs presented by the participants based upon where they were in the stages of placement. The concept of children presenting different behaviour based upon their stage of placement (Bayless, 1990; Fine, 1993; McAuley, 1996; and Palmer, 1995) was certainly observed in this group. The participants had different placement histories and experiences which impacted upon the group process in a significant way.

Children presented issues or related to the identified issues based upon their own

context and experience. The participant who had only been in care for four months at the time of the group had many different needs and issues than the participant who had been in care for 11 years (e.g., connections to birth families, dealing with the pain of separation and loss, coping with the changes in where you live, go to school, etc.). It made it sometimes challenging for the facilitators to have the content be relevant to all the participants. A technique was utilized in which the experiences of the children who were past Stage Three of placement (McAuley, 1996) were considered to have "expertise" that they could share with the other participants (e.g., how they dealt with a particular issue that another participant was beginning to experience, has this ever happened to you?, and how did you feel?). This helped to keep all the participants involved in the discussion at hand.

This technique was extended in general to all the group participants by capitalizing on their experiences and promoting them as experts who had information to share with other children who were entering care after them (e.g., What would you have to say about ____?). This motivated the participants to want to capture their thoughts and experiences in a book form which might be offered to other children entering care. This was a unifying theme throughout the group and provided direction to many of the activities and tasks which were captured in the children's journals.

This diversity of the experiences of the participants added a great deal to the group process. One participant was entering a court process to determine her Permanent status. She was very concerned about going to court and struggling with the idea that she had to

choose and that the decision was up to her. With input from other participants and some educational information from the facilitators on the court process, this child was helped to prepare for and cope with the court experience. A role play was used to illustrate what she could expect in court and she was helped to express her fears and concerns and encouraged to follow up with her worker. This, she reported, she was able to do. There were several other examples of participants bringing their issues and needs to the group for discussion (e.g., having a visit with family, going to court, confusion over the social worker role, etc.). In this way, the group met the objective of providing the participants with the opportunity to talk with other children in care about their separation experiences and needs resulting from being in care.

A problem with the wide range of care experiences was that, on occasion, some participants could not relate to the topic at hand as it was not directly relevant to them at that time. The facilitators tried to highlight any connection for the participant so that he or she could relate to the topic. Also, not all of the issues could be dealt with in the group setting. Some of these were funneled to the participant's worker (e.g., a participant wanting to know more about a lost birth sister) for follow up with the participant.

Children vary greatly in how much they can and should open up while in group treatment (Kandaras, 1985). Some of the participants were able to share a great deal of their experiences of being in care and their feelings with each other during this stage. This marks an internalization of the group process and an increased commitment to the group (Lewis, 1985). The participants talked about being abused, about being scared and

frightened while in their biological parent's care, about contact with birth family members, about being angry at their birth parents, foster parents and social workers for a variety of reasons, etc. There was good eye contact and empathic listening between participants for the most part. Communication and interaction patterns between participants were comfortable. It was apparent to the facilitators that connections and relationships had been made between the participants.

During this middle stage of group, many issues for children in care were explored. Facilitators directed some of these issues, while many were initiated by the participants themselves. Some of the issues explored in the middle stage included: (a) feelings about living in a foster home, (b) some of the reasons why children are in care, (c) do you know the reasons why you are in care?, (d) what is a parent's job?, (e) why kids may think that being in care is their fault, (f) feelings about their birth families, (g) what is the role of a social worker, (h) what is family court like and what do I do there?, (i) what are some of the things we get from our birth family, (j) different kinds of placements and legal status for children, and (k) differences and commonalities between their birth family and their foster family.

These issues were approached in a variety of ways by the facilitators which were sensitive to the child's context and circumstances. McMillen and Groze (1994) detail the use of placement genograms as a tool in helping children in care to describe and discuss salient issues in their lives. We utilized this technique to reinforce the concept of transparency (Vogrincic, 1990) for the participants in their having two families, a

biological family and a foster family, and to look at who was in those two families.

The use of transparency in talking about all these issues was an important communication tool. When participants shared about their family, they were asked if they were referring to their birth or foster families. This concept was also helpful when participants were identifying issues in their foster homes (e.g., conflicts with foster siblings, being disciplined and being told no etc.). It was sometimes confusing to me which family a child was talking about as the issues often overlapped.

For the participants who had been permanent wards for some time and had no contact with their birth family, or those who had experienced a number of placements (both agency and extended family), there was some confusion for them between the different families in their lives. This highlighted that considerable work remains (for the agency, worker, care giver) in supporting these participants understanding their placement histories and connections to different families.

Another technique the participants enjoyed was completing a time line diagram in which significant events in their lives were recorded. This provided information in a visual fashion about the child's life which can be helpful to his or her understanding present feelings and behaviour (Palmer, 1990). What was significant in completing this activity was how little information the participants seemed to know or remember about their lives. This type of information is considered important to a child in coping with his or her care experience and reducing self blame by helping the child to recognize those events over which he or she has no control (Palmer, 1995). With this activity as the starting point, a

great deal of information was reviewed for each participant, including the number of years in care, reasons why they came into care, number of different placements, schools, social workers, etc. Other techniques utilized to approach these issues for the participants included completing in dyads more interview sheets, reporting back to the larger group, creating "word splashes", brainstorming, and summarizing through exit slips.

The child who had participated in the Family Group Conferencing (FGC) process seemed to bring the fewest issues to the group during the middle phase. He presented as a content child who was fairly quiet and passive throughout the group process. He certainly seemed to understand why he was in care and he accepted this as well. He often shared positively about his foster and birth families, and talked about his contact with his birth family. He appeared to be a child who may have perceived himself to have been in charge of the move (Fahlberg, 1988) when he became a permanent ward. This outcome might be understood as one of the expected outcomes of the FGC process, or it may have more to do with the verbal and social skills of the child.

Stage 4 Group ending

The termination stage of a group concerning separation and loss issues has some special significance. All the participants are already coping with the realities of separation from their birth families. It was important to consider how the separation from this group experience could be supported so that the participants could be empowered by the ending of the group and have a positive feeling of its accomplishments and their participation. Facilitators need to develop an "atmosphere to help the child and the group rework some

earlier losses while also dealing with the group's end" (Herndon, 1985, p.162). The goal at the ending of this group was to help the participants to have a sense of moving forward.

As is often the case in children's groups, at the time that termination is occurring, the participants have started to feel connected and close to each other (Siepker & Kandaras, 1985). In this group, the facilitators observed a great deal of positive chatter and interaction among the participants. Participants demonstrated caring for others, looked forward to the arrival of the other participants and noticed when others were late or away. At the beginning of the final sessions, there was often a lot of discussion to get caught up with each other for the past week. This occurred across gender boundaries as well. Observation of the group interaction during the ending stage indicates a nice level of comfort among the participants. There was an ease to their interactions as participants moved freely around the room.

In session nine the facilitators reminded the participants that the group was coming to an end, and started identifying remaining issues and any outstanding questions. In children's groups there are often separation reactions and the emergence of coping behaviors at the announcement of the ending of group (Herndon, 1985). Some of these reactions contain elements of denial, anger, regression, hostility, acting out, grief, relief, joy and pride. The termination of this group was dictated in part by the design of the group intervention (ten weeks) as opposed to being determined by the progress towards achievement of group and individual goals. In some ways, termination of this group felt premature. Herndon (1985) suggests that group termination minimally takes three

sessions.

There were few signs that the participants started to panic about the separation and loss of the group. Participants helped to plan the final session in which we celebrated the end of the group and the gains made. Tasks for facilitators include reminiscing, reconfirming gains made and looking forward to the future (Herdon, 1985). A closing ceremony was held and participants were given a poster and a group picture. The posters had been selected by the facilitators to signify a quality of that participant. The participants decided to sign each others' group pictures. During the ending session, participants were very comfortable with each other. The girls brought some CDs and were dancing to the music. There was a pizza and soda pop celebration. The group ended at the same time that the school year was ending as well, so there was a great deal of excitement and discussion about the coming summer plans.

Overview of parallel process for care givers

The parallel process with the care givers did not happen as planned. Certainly it was a goal of the parallel process to provide support, education, and networking opportunities for care givers. This goal had been identified as a critical one in the support of care givers (Steinhauer et al., 1988, 1989). There were several individual interviews, phone calls, letters, notes and contacts around dropping the child off for group between the group facilitators and the care givers during the life of the group. However, the planned meetings as a support group were not successful.

The first meeting was scheduled to occur on a week night evening. Only two

foster parents attended this meeting. Letters had been sent out to all the care givers but only one had called to send regrets. In follow up with the care givers, they indicated several reasons why they could not attend. The two foster parents who did arrive were interested in discussing some of the issues related to supporting a child in care with their experience of separation and loss. The facilitators had planned to follow some of the curriculum developed for workers on separation, placement and reunification (Rycus et al., 1988). The second meeting was planned for about the 5th week of group. In calling care givers ahead of time, only one would commit to coming, so the meeting was canceled. The third scheduled meeting was abandoned as it was apparent that this format was not working.

In the pregroup planning stage care givers had been reluctant to accept any focus upon them. One referred child did not end up attending the group as the care giver resisted the idea that the child could benefit from the group. Four of the seven care givers were slow in getting the posttest measures back; one care giver refused to complete any of the measures as she felt they were intrusive of her family's privacy.

In subsequent discussions with the supervisor of resource development, she indicated that care givers often present this way when the agency attempts to provide training and support. Recent orientation sessions for prospective care givers (foster parents) drew only 10% of expected participation. The agency has tried to offer training in many varieties of format, with little change to the participation rate by care givers. Care givers only accept a focus on the child and not on themselves. The agency experience

generally is that care givers are reluctant to participate in development opportunities, and this is especially true for the more experienced care givers. It was interesting to note that the two care givers who did attend the first support meeting were the most experienced among this group of care givers. Perhaps, they were the most confident in their foster parenting and were willing to risk by coming to the support group.

Families place a good deal of emphasis on being "normal" and "healthy". Families worry about their own normality and judge themselves if they do not fit the socially desirable standard. Walsh (1998) found in her years of family research that participating families wanted confirmation that they were normal. Other families declined to participate fearing that under scrutiny, they would be found abnormal. Walsh found that family "resistance" to participation in research and in seeking support were because they fear being judged dysfunctional and deficient. Such a fear could prevent foster families from participating in any practicum which has any focus upon their functioning as a family.

In the agency-foster family relationship, such a judgement could be perceived as having a direct impact upon their role as a foster family, and could further impact upon their relationships with their foster children (i.e., removal of the child and having a financial impact if their foster home letter of approval was removed). This concern may also have an impact upon the validity of care giver responses in the completing of the measures. Another possibility for the lack of participation of care givers is the reality that many of the foster families have busy, active lives and it was not feasible for them to attend an evening meeting in the early summer. Three of the families were rural, so their

participation would have involved travel and expense. All of the care givers would have had to plan for child care needs as well. These needs were not anticipated in the planning of this aspect of the parallel process.

A further influence upon care giver participation may relate to the adversarial relationship between foster parents and the provincial government which has cut back on financial and training supports to foster parents. At the same time, standards and expectations for foster parents have increased significantly. This has changed the relationship between agencies and foster parents, from one of altruistic care giver to that of a professional parent. Also, it was important that I not relate to care givers in any coercive way and this perhaps limited any "leverage" I had with which to influence the care givers to participate.

Chapter Five: Evaluation and Summary of Measures

Introduction

Four measures were applied at pretest and posttest to help evaluate the effectiveness of the group intervention. The following review highlights the findings, but the reader is reminded of the previous discussion of the limitations of the conclusions.

PSI

One care giver refused to complete the PSI which was administered both at the pretest and posttest stages. On both occasions, the PSI was hand delivered to care givers and some direction provided. The care giver who was providing care to two of the participants completed two separate PSI forms as the measure relates to the stress experienced in parenting a particular child. Most of the measures were completed by the foster mothers. In one case, the PSI was completed conjointly by the care givers. Table 3 summarizes the PSI percentile scores for the care givers at the pretest and posttest stages.

At the pretest stage, two of the care giver systems reported Total Stress (TS) scores greater than the 85th percentile, one was significantly higher at the 96th percentile, with the other four care giver systems reporting scores within the normal range for TS scores (i.e., between the 15th and 85th percentiles). Levels over the 85th percentile are considered clinically significant indicating a care giver-child system that is in trouble or is heading toward trouble. Referrals for professional help should be considered for families at this level (Abidin, 1986).

Table 3

Percentile Profiles for the PSI at Pretest and Posttest.

		Child Domain	Parent Domain	Life Stress	Total Stress
Caregiver 1	Pretest	n/a	n/a	n/a	n/a
	Posttest	n/a	n/a	n/a	n/a
Caregiver 2	Pretest	**99**	6	**95**	**87**
	Posttest	**99**	6	55	79
Caregiver 3	Pretest	**99**	66	76	**96**
	Posttest	**97**	53	35	**88**
Caregiver 4	Pretest	73	36	1	54
	Posttest	77	30	1	50
Caregiver 5	Pretest	**86**	50	35	69
	Posttest	**93**	49	65	77
Caregiver 6	Pretest	57	37	1	40
	Posttest	45	37	1	37
Caregiver 7	Pretest	65	80	**90**	80
	Posttest	42	79	**99**	73

Notes: All scores represent percentile scores. Care giver 1 refused to complete measures.

Scores in **Bold** fall in the clinically significant range.

Except for the care giver who refused to complete the measure, none of the respondents at pretest had a Defensive Responding (DR) score which might indicate that they had responded in a defensive manner, i.e., a DR of 24 or less. Two of the care giver systems reported Life Stress (LS) scores above the 85th percentile. LS represents stress on the care giver system which is beyond their control. High LS scores intensifies the total stress that the care giver is experiencing (Abidin, 1986). None of the care givers reported clinically significant (above the 85th percentile) scores in the Parent Domain, (i.e., dimensions of the parental functioning which may represent sources of stress and potential dysfunction of the parent-child system). Three of the care giver systems reported significant scores in the Child Domain, which indicate that characteristics of that child are a major influence upon the overall stress that the care giver is experiencing (Abidin, 1986).

At pretest for this group of six care givers, there was a majority who were reporting clinically significant percentile scores for the PSI, either Total Stress, Child Domain or Life Stress areas. This is consistent with the knowledge that care giver systems experience significant stress as a result of parenting children who come into agency care (Fanshel et al., 1989; Fanshel & Shinn, 1978; Jewitt, 1982; Lawder et al., 1986; McKenzie, 1997; Pilowsky, 1995; Steinhauer, 1991).

At posttest, decreased TS scores were reported by five of the six care giver systems, with the largest decrease being 8 percentile. Three of the care givers systems reported significant levels in the Child Domain score (above the 85th percentile) which was the same as at pretest. There were some large decreases in Child Domain scores for

two of the care giver systems (12 and 23 percentile points). Decreases in the Parent Domain scores were reported by four care giver systems, with the largest being a decrease of 13 percentile points. The remaining two care giver systems reported no change in their Parent Domain score.

At posttest, two of the care giver systems reported increases in their Life Stress scores, two reported large decreases in their Life Stress, while two remained the same. The writer is not aware of the reasons for the large changes, both positive and negative, in several of the Life Stress scores reported by the care givers. These are changes which occurred over a relatively short period of time (three to four months) and which are beyond the control of the care giver, i.e., indicated by care giver responses to questions relating to marital, financial, health, employment and drug addiction areas of personal functioning. These sources of stress also lie outside the influence of the Child Domain, but do intensify the other stressors experienced by the care giver (Abidin, 1986). There appears to be no differences in the PSI scores for care givers of Temporary wards compared to care givers of Permanent wards. One care giver system has a Defensive Responding score of 24 which indicated that she may have been responding defensively.

The reported scores for the PSI at posttest indicate little overall decrease in the stress and challenges experienced by care givers following the group intervention. This is perhaps not surprising given the fact that the parallel process did not occur as planned, and the period of time was relatively short in duration (three months). The need for the agency to provide support and education to care givers remains high.

CBCL

The summary of the care givers' assessments of the children in their care at both pretest and posttest stages are reported in Table 4. The CBCL was hand delivered to care givers at both stages with some direction being provided. As indicated above, one care giver refused to complete any of the measures, so the number of respondents is six.

T scores above 70 are considered clinically significant (greater than 98th percentile). *T* scores between 67 and 70 (95th to 98th percentile) are considered borderline clinically significant. The borderline range was chosen "to provide efficient discrimination between demographically matched referred and nonreferred samples...while minimizing the number of 'false positives,' i.e., normal children who score in the clinical range" (Auchenbach, 1991, p. 56). For the CBCL, there are several reported *T* scores which fall into the clinically significant range (above 70). Appendix I illustrates a comparison of the CBCL *T* scores for this group at the pretest and posttest stage to those of the normative samples found in the CBCL manual (Achenbach, 1991). Several of the reported scores for Internalizing, Externalizing and Total problems scales are significantly elevated for the participants in the group (> 1 or 1.5 SD.), while Total Competency scores are correspondingly lower for the participants in the group. This is at both the pretest and posttest stages. This is not surprising given the knowledge that children in care are more likely to present with behavioral, social, educational and emotional problems than children not in care (Colton et al., 1991; Fanshel et al., 1989; Fanshel & Shinn, 1978; Jewitt, 1982; Lawder et al., 1986; Pilowsky, 1995; Steinhauer, 1991).

Table 4

T Scores for the CBCL at Pre and Posttest.

		Total Competency	Internalizing	Externalizing	Total Problem
Child 1	Pretest	n/a	n/a	n/a	n/a
	Posttest	n/a	n/a	n/a	n/a
Child 2	Pretest	39	67	74	74
	Posttest	38	65	77	75
Child 3	Pretest	47	71	74	79
	Posttest	55	66	75	74
Child 4	Pretest	39	58	66	65
	Posttest	39	57	67	65
Child 5	Pretest	32	58	65	66
	Posttest	26	49	60	59
Child 6	Pretest	39	65	69	70
	Posttest	41	64	70	74
Child 7	Pretest	34	52	51	53
	Posttest	45	56	51	55

Note. The care giver for child 1 did not complete the CBCL. *T* scores in bold fall into the clinically significant range.

It is possible to compare the pretest and posttest CBCL outcomes for this group using the participants' *T* scores for Internalizing, Externalizing, Total problem and Total competence scales even though there are multiple sex and age differences within the group (Achenbach, 1991). This allows for some assessment of the impact of the group intervention upon the problems experienced by these children in care. The mean for Total Competency for the group participants increased from 38.3 (pre test) to 40.67 (posttest) (n=6). This increase is small, but it is in the positive direction (i.e., movement to an increased level for Total Competence is a positive change).

The group mean for Internalizing Problem scores dropped from a mean of 61.8 (pretest) to a mean of 59.5 (posttest). Again, this small change is in a positive direction (i.e., lower scores on the problem scales are a positive change), yet, the scores still remain high above the standardized norms. The mean for Externalizing Problem scale remained virtually unchanged (66.5 pretest vs. 66.67 posttest), as did the mean for Total Problem scale (67.8 pretest vs. 67.0 posttest).

In conclusion, when comparing group means for the CBCL at pretest to posttest, there is virtually no change. Any change is so small that measurement error could be the reason, and not the group intervention. The group means at posttest remain significantly higher than standardized norms (See Appendix I).

TRF

The TRF is designed to be filled out by teachers who know the child, and seeks to have the teacher describe the child's behaviour. This allows for comparison between the

care giver report and the teacher report to triangulate data. The TRF was mailed out to the child's teacher at both pretest and posttest stages with a covering letter (See Appendix F). Table 5 summarizes the TRF profiles for the group participants at both pretest and posttest stages. The normal, borderline and clinical ranges of the CBCL are used with the TRF to assess the significance of a respondent's *T* scores. There is only one reported *T* score in the clinically significant range (above 70) for the TRF scores. Appendix J illustrates comparisons between the TRF scores reported by teachers for the group participants and the normative samples (Achenbach, 1991).

It is interesting to note that the teachers reported much lower *T* scores for the participants, than did the care givers. Generally, the TRF scores are closer to the normative means (< 1 SD.) than those reported by the care givers in the CBCL. One teacher called me when she received the TRF to assure me that the child was doing well and that the agency should not be concerned. There was one participant where this was not the case. Child 2 had TRF scores which were equivalent to her care giver CBCL scores; both were well above the normative means for her gender and age group (usually at least one or two standard deviations difference). For Child 3 and Child 6 there were substantial differences between *T* scores for the CBCL, completed by their care givers, and the TRF, completed by their teachers.

There could be a number of possible reasons for these discrepancies. Teachers may be more objective in assessing child behaviour given their professional role with a child and their comfort in completing child evaluations. Care givers may be experiencing

Table 5

T Scores for the TRF at Pre and Posttest.

	Adaptive Functioning	Internalizing	Externalizing	Total Problem
Child 1 Pretest	44	48	40	55
Posttest	**44**	**54**	39	**55**
Child 2 Pretest	**38**	**74**	**57**	**68**
Posttest	**35**	**68**	**57**	**67**
Child 3 Pretest	**43**	**45**	**49**	**49**
Posttest	**46**	**51**	**42**	**45**
Child 4 Pretest	**46**	**48**	**59**	**53**
Posttest	**39**	**45**	**59**	**53**
Child 5 Pretest	**35**	**56**	**62**	**63**
Posttest	**35**	**59**	**62**	**63**
Child 6 Pretest	**42**	**55**	**56**	**56**
Posttest	**41**	**53**	**56**	**56**
Child 7 Pretest	**37**	**45**	**59**	**55**
Posttest	**43**	**45**	**61**	**56**

Note. *T* scores in bold fall into the clinically significant range.

parenting stress which influences their perception of the child's behaviour. In the child welfare system, care givers are financially compensated according to the child's level of need which is determined through Child Service Plan (CSP) assessments completed by the care giver and the child's worker. Thus there may be an incentive to rate the child's behaviour in more problematic terms. Also, children in care may behave differently between the school setting and their foster home because of their comfort and safety level in the different settings.

Similarly to the CBCL, differences in group means of *T* scores for Adaptive Functioning, Internalizing, Externalizing and Total Problem scores for the TRF can be compared at the pretest and posttest stages to assess if there is any difference following the group intervention (Achenbach, 1991). There were almost no changes when comparing group means for the TRF and its subscales at pretest to posttest. Adaptive Functioning group means were 40.7 at pretest, compared to 40.4 at posttest (n=7). Group means for the Internalizing Problem Syndrome rose slightly from 53.0 at pretest to 53.5 at posttest. Moving slightly in the positive direction, the group means for the Externalizing Problem Syndrome fell from the pretest to posttest comparison (54.7 to 53.7, n=7); as did the Total Problem score (57.0 to 56.43, n=7).

In conclusion, there was virtually no change in the group means for the TRF Syndromes at pretest and posttest. TRF group means were however, much closer to standardized norms (See Appendix J) indicating that teachers reported much less problematic behaviors than did the care givers.

The *T* score data for the CBCL and the TRF were analyzed further to determine if there were any significant findings when comparing the group means for Temporary and Permanent wards. For the CBCL, the group mean for Total Competence for Temporary wards rose from 33 pre test (n=2) to 35.5 posttest. Similarly, the group mean for Total Competence for Permanent wards rose from 41 pre test (n=4) to 43.25 posttest. The Total Competence means for Permanent wards were more positive than those for the Temporary wards.

The Total Problem group means for Permanent wards remained unchanged; 72 at pretest and posttest (n=4). For the Temporary wards, the Total Problem group mean fell from 59.5 at pretest (n=2) to 57 at posttest. The comparison of the group means for Total Problem *T* scores between Temporary and Permanent wards indicates a much lower Total Problem mean for Temporary wards.

For the TRF, the group mean for Adaptive Functioning for Temporary wards rose slightly from 36 pretest (n=2) to 39 posttest. The group mean for Adaptive Functioning for Permanent wards fell slightly from 42.6 pretest (n=5) to 41 posttest, yet remained higher than for the Temporary Wards. The Total Problem group means for Permanent wards fell slightly; 56.2 at pretest (n=5) to 55.2 at posttest. For the Temporary wards, the Total Problem group mean rose slightly from 59 at pretest (n=2) to 59.5 at posttest. Again, the TRF group means were more closer between Temporary and Permanent wards than were the means of the CBCL.

Piers-Harris Children's Self Concept Scale

The Piers-Harris Children's Self Concept Scale is a self-report measure which looks at children's feelings about themselves. This measure was given to the participants in the first and last group sessions. It was completed individually during group time. The participants were told there were no right or wrong answers, but rather to try and answer honestly. One participant needed the questions to be read to her as her reading skills were weak. One participant asked to take a copy of the questions home as he was intrigued by them. Table 6 summarizes the *T* scores for the participants both at pretest and posttest stages.

Average scores are between the 31st and 70th percentiles. Clinically significant scores (plus or minus 1 standard deviation) , are below the 16th and above the 84th percentiles (Piers, 1984). There were no responses which were considered clinically significant, although Child 5 presented with the lowest self concept *T* scores. Her Total Score at posttest was significantly reduced, although there were validity concerns with her response.

There are two validity indexes which are designed to cope with the validity threats inherent in a self-report measure. The Inconsistency Index helps to detect random responding by the child. A raw score of 6 or more on this index suggests that a child may have responded randomly to at least some of the items for a variety of possible reasons (Piers, 1984). There was one response in the posttest stage which indicated a random response pattern (Child 5).

Table 6

T Scores for the Piers-Harris Children's Self Concept Scale at Pre and Posttest.

		I	II	III	IV	V	VI	Total Score
Child 1	Pretest	47	52	60	59	45	63	55*
	Posttest	39	55	60	49	39	63	49
Child 2	Pretest	47	59	65	52	55	56	58
	Posttest	45	59	60	49	51	56	56
Child 3	Pretest	66	63	69	59	55	64	74*
	Posttest	66	63	69	63	61	63	79*
Child 4	Pretest	50	63	64	55	55	69	60
	Posttest	54	55	64	55	55	64	59
Child 5	Pretest	50	43	43	39	43	47	46
	Posttest	39	41	34	31	34	32	36*
Child 6	Pretest	59	70	60	63	55	63	69
	Posttest	66	70	69	69	69	63	80*
Child 7	Pretest	66	63	69	69	69	63	77*
	Posttest	58	58	69	59	61	56	68

Notes: Cluster headings; I= Behaviour, II= Intellectual and school status, III= Physical appearance and attributes, IV= Anxiety, V= Popularity, VI= Happiness and satisfaction. * Responses having validity concerns

The Response Bias Index assesses the acquiescence and negative responding patterns by respondents. The items on the Piers-Harris measure are balanced in the direction that the questions are phrased, i.e., a balance between positive and negative self esteem statements If the index value is greater than 52 or less than 24, it may indicate that the child has responded in such a fashion (Piers, 1984). There was one response at the pretest stage which is of concern (Child 1).

A further validity concern is that of social desirability in which the child tries to portray him or herself in a positive fashion. Total scores which are 1.5 standard deviations or more in a positive direction, i.e., raw scores of 70 or above, may indicate a child responding in a desire to appear socially desirable (Piers, 1984). There were four responses which may indicate a "faking good" response.

Subjective evaluation

In the ending stage of group, the participants were asked if they had any concerns or questions about the group or any suggestions to improve the group. The feedback from the participants was positive. The participants indicated that they enjoyed the group experience and were glad they had participated. Some appreciated the opportunity to meet other kids in care and to talk about being in care. There was some discussion about planning a follow up meeting in the fall to touch base. There was no attrition in the group over the ten weeks. Participants came on time and often wanted to stay later. There were a couple of weeks when sports activities took participants away early. But generally, commitment to attending the group was very high.

Care givers were asked through a survey for subjective feedback (See Appendix H). Their comments indicated that they had not perceived much change in the behaviour of the child. Some of the care givers indicated they did not have an idea of what their child had done during the group. Others felt that the opportunity for their foster child to talk about his or her issues with other children had helped a great deal. There was little comment in regards to the parallel process.

In the year following the group intervention, there have been some significant developments for this group of children. The two Temporary wards became Permanent wards shortly following the end of the group. These children appear to be secure in their placements at this time. One placement has broken down. Care giver Three had clinically significant levels of Total Stress as reported in the PSI at both pretest and posttest. Although scores at posttest had shown improvement, this placement continued to experience difficulty and subsequently broke down. This child has been placed into another foster home, after over four years of care with this care giver. This placement had been for a sibling group of three which placed significant stress upon the care givers. These care givers have since "retired" from fostering. Two other placements have deteriorated, according to the child's worker. There has been requests for follow up group intervention to try and support these children in their placements.

Summary

The group appears to have been able to support care givers in understanding and coping with the separation needs of the children in their care. There appears to have been

some positive changes following the group intervention in the parenting stress experienced by the care givers for these children in care. Five of the six care giver systems reported decreased Total Stress scores on the PSI at posttest. Two of the six care giver systems reported large decreases in the Child Domain at posttest. Four of the six care giver systems reported decreases in the Parent Domain at posttest. The Life Stress scores reported by the care givers were mixed. Some of the PSI scores at the posttest stage remained at clinically significant levels (above 85th percentile).

The group intervention had little impact upon the children's problem behaviors and competencies as measured by the CBCL and TRF. Many of the reasons for this lack of change are outlined in the limitations of the evaluation plan. As well, increases in problem behaviors could be anticipated as a result of the child having the opportunity, perhaps for the first time, to begin to sort out and express complex feelings related to his or her coming into agency care (James, 1989).

The success of the group is best measured by the extent to which the children felt supported by the group to talk about their own experiences of being in care. Given some direction, opportunity, permission and support they were able to open up to each other in talking about their separation experiences. This is not measured so much by any pre-post testing, rather by the growth and change demonstrated by the participants over the duration of the group. The group did achieve its purpose in giving each child an opportunity to recognize and explore feelings about being in care.

Chapter Six: Reflections

Introduction

This opportunity to work intensively with a group of children in care (and their care givers) was very rewarding and challenging. The experiences with which these children are coping are significant. Learning from their experiences could impact upon the many children who will come into agency care. This group experience has demonstrated the potential to compliment the efforts of care givers and workers and has provided some direction for future interventions. What the children (and their care givers) shared through the group experience suggests the extent to which services are meeting the needs.

Emerging themes in group process

1. Participants constantly identified not knowing the reasons for decisions made in their lives (i.e., frequency of visits, canceling of visits, etc.). Some of this may have been the participant projecting his or her feelings about a particular decision (e.g., anger, sadness, relief). But there were several instances when it appeared to be a lack of understanding on the part of the participant about how or why a particular decision was made about his or her life. Facilitators encouraged the participants to approach their worker with their questions.

At this developmental stage, pre and early adolescent, this lack of involvement in

decision making is not always appropriate (Palmer, 1995). There are several reasons why children may not be involved in decision making, ranging from a lack of time and energy on the part of the court, the worker and the care giver to involving the child, to the adults in the child's life wanting to protect and shelter the child from feeling responsible for the making of decisions. Workers and care givers could improve upon the level of involvement that the child feels she or he has in these decisions.

2. The participants were able to be appropriate with each other as feelings were shared and discussed. Many issues and needs arising from separation and living in care were able to be addressed in the group format. A group intervention for children in care can be an effective way to support children in sharing their complex feelings and experiences around separation and coming into care and to explore their understanding of what happened to them (sorting out). The combining of genders in this group did not appear to create significant problems, but rather added to the group experience and development of appropriate social skills at the early adolescent development level.

3. It was clear over the duration of the group that most of the participants were well placed. Care givers valued the children in their care and the children demonstrated a great deal of security in their placements. The general stability of the placements for the participants allowed for issues other than those related to placement disruption and conflict to be explored in the group (i.e., birth family, school and peers, feelings, genograms, etc.). Participants who were experiencing placement difficulties were able to share these at the group level and gain some support from the other participants. There is

a concern for a group of children in care that this could become the primary focus of the group intervention.

4. Having participants with a combination of temporary and permanent legal statuses was an enriching aspect of the group as there were a variety of issues identified by the participants. For the two children who were temporary wards, this difference in legal status had been an issue for them while in group and some work had been done on their sometimes conflicted feelings towards becoming permanent wards. The downside to having this variety was that not all of the participants, given their social skills, were able to relate to topics which did not have a direct impact upon them at that time. The facilitators had to try and make connections for some of the participants during these discussions.

5. Many of the participants lacked basic factual information on their own lives. This is considered to be important information for the child to have when dealing with experiences of separation and loss (Palmer, 1995). It highlights for the agency a need that is not being met for some of the children in its care. This need is especially significant given that the majority of CIC in the group (and within the agency) are permanent wards which suggests that they are at risk of losing contact and connection with their birth families. Palmer (1995) suggests that this loss of contact with birth family can have a significant impact upon the child's progress while in care.

6. There was some risk that the participants would feel that there was something wrong with being in care (the risk of pathologizing the participants by having a group intervention for children with a focus upon being in care). This was addressed directly

when one participant asked and then answered the question for herself during a group session. This sharing then evolved into the participants identifying what they had gained (and lost) by coming into care. The facilitators were required to consistently reflect a realistic and positive perspective on being in care.

7. The timing of the group experience for each particular child, in relation to the stage he or she was at in his or her separation and care experience, influenced his or her presenting needs in the group and his or her participation in some of the activities. The group appeared to be most "timely" for the two participants who were temporary wards as they brought the most issues to the group for discussion and feedback. The issues they were coping with were happening to them while the group was running. For the participants who were permanent wards, many of their issues brought to group were not as directly impacting upon them and their daily lives. Thus, the group process may have become biased towards those issues which directly concerned the participants who were temporary wards. This is not to say that these issues were then irrelevant to the participants who were permanent wards, as the facilitators were able to try and connect to everybody's experience as described earlier. Rather, it may indicate a need to plan future group interventions with groups that are more homogenous as to their placement histories. Numbers within this smaller agency may make this impracticable.

8. The use of play in this group was important to promoting the cohesiveness and developing the context for sharing of feelings to occur. The play activity was moved to the beginning of the session, rather than at the end. This was because of the need to work

off some of the energy that participants brought to group. Also, facilitators need to consider the degree of physical contact and interaction required for the activity, especially in a mixed gender group. In the beginning stages of this group, physical contact within a mixed gender group at this developmental level was not successful.

9. The lack of involvement by care givers is a concerning theme of this group intervention. As discussed, this is typical of the agency's efforts to provide training and support to its foster parents. Other efforts and methods of engaging foster parents need to be explored. This need is especially important given the high levels of stress reported by care givers involved in the practicum. Some ideas to improve on this response from care givers includes: (a) working closely with the social workers who provide support to the care givers, as the trust and relationship between care giver and support worker has an influence upon acceptance by the care giver of the intervention; (b) utilize the Westman Foster Parents' Association as an advocate to encouraging care giver acceptance and participation through presenting to the association the results of this practicum and discuss relevant issues and suggestions for improvement; and (c) work with the agency management in identifying other ways of improving the support and training offered to care givers.

Issues and implications for group work with children in care

The initial contacts at the pregroup planning stage highlighted how important it was to know your group. Facilitators have to constantly consider the child's age, developmental stage, life stage, state of crisis, life perspective, and degree of socialization.

What might happen when these children are brought together as a group beyond the identified goals and needs (e.g., what are the unanticipated outcomes?). Facilitators have to anticipate, then see what the participants bring.

One of the issues when working with kids in group was how much the children differed in their capacity to share their perspectives and feelings. There were also large differences between the children in terms of their memory or ability to recall information. This was not surprising given the differences between the participants' placement histories. What the children were able to remember about being apprehended differed between them (as did their ability to share this information within a group). There was some question as to whether they had specific recall of these memories, or whether this was the result of any "memory work" that may have been done with them over the years by their social worker or care giver (what they remember as opposed to what they have been told). For example. one participant had memories about a birth sister she had never met. A helpful technique in trying to assess this distinction was to ask the child do you remember that or did someone tell you that? This was one of the ways in which the developmental levels of the children had a significant impact upon the group's functioning.

Facilitators needed to learn to follow the lead of the participants and not to be too focused upon attempting to complete the agenda for that week. It was noticed that as the facilitator, I had the tendency to provide the answers for the participants when things bogged down, rather than trying to let the participants struggle with the silence. Participants were persistent in trying to make the facilitators guess their feelings by

responding to questions about feelings with, "I don't know?". This provided the participant with some power and control in the sharing of information. Facilitators needed to learn how to pace the questions and to tolerate gaps.

The suitability of the PSI measure is an issue to be resolved for future groups. One care giver refused to complete any measures as a result of her anger over this measure, particularly the personal questions. Other care givers also found that the measure did not seem to fit their experience. Several of the questions are framed to measure change in parenting stress after the parent " took the baby home from the hospital". Whether or not this measure works for alternative care givers of children in care is a question. In retrospect, more effort should have been made to discuss the concerns of care givers prior to their agreeing to participate in the practicum. Greater explanation about the purposes and need for measurement should have been provided.

Working with the care giver system remains an important component to any group work with children in care (James, 1989). The care giver can benefit from support and education. The gains made in group for the child can be enhanced through care givers echoing the materials covered in group. Attachments to care givers can be strengthened through the care givers' active involvement in the group process. In a follow up phone conversation with one of the care givers who participated in the program, she shared her perception that she does not feel listened to by the agency and that her observations, reports and beliefs about the child are discounted by the agency. She expressed frustration with the workers and "the system". These are all feelings that a care giver support group

can help care givers to cope with more effectively. I am convinced that the benefits of a support group are significant, even though this was not demonstrated in a positive sense by this practicum.

Chapter Seven: Evaluation of Student Learning, Recommendations and Conclusions

Evaluation of student learning

This practicum provided me with the opportunities to gain knowledge about separation and loss issues for children who come into agency care and how to use that knowledge in supporting children in a group intervention.

I learned that I needed to examine what my assumptions are about family normality and foster family normality. I need to find different methods of connecting with care givers. This is similar to the experience of the agency in working with groups of care givers.

I learned that in a co-facilitation situation, my style is one of tending to take the lead. The interactions between the facilitators highlighted this. Strategies were discussed and used to try and create more of a balance between the roles of the facilitators. It was important for the participants to observe a mutuality and respect between the facilitators.

An issue I needed to work through was the need to balance focusing on one participant's identified issue versus wanting to stay close to the agenda which had "perceived" relevance to all. I learned I needed to relax in trying to accomplish what I had set out for the group and to allow the children's needs to direct the activity of the session. Strategies and techniques were discussed in supervision to see that there was value in both and to be able to return to issues that were perhaps not dealt with in great enough detail. What emerges in the group tells an agency which of their client needs are not being met.

The experience of the group should feed into agency support of foster parents and its children in care. Over the duration of the group, facilitators learned to follow the lead of the participants and not to hold tight to the planned agenda.

I learned I needed to look at my leadership style and evaluate its appropriateness in terms of: (a) what is desired style for that particular purpose; and (b) what skills are needed to support that style? My values affected how my style comes out. The style of leadership should match the needs of the group and children in the group. When you take on a directive style, you assume much responsibility.

I learned that expectations of a group need to be realistic.

As a group facilitator, I learned that I needed to watch the language that I used in framing certain questions. Facilitators need to avoid value loading a question that they pose to participants. This includes, for example, questions about contact with birth parents (e.g., Do you feel you have enough contact?). This becomes a very loaded question to the participant and implies that the current plan could or would be changed or altered in some way and that the current arrangement is inadequate. Also, as facilitator, I need to avoid presenting as being defensive about the system (e.g., trying to defend a judge's decision to a participant).

Recommendations

Workers engaged in this type of work (group intervention to support children in care) must be provided with support from within their agency in order to sustain the

energy and motivation level necessary to successfully meet the challenges such a group provides. The agency recognizes that there is a need for this type of group intervention for its CIC. The offering of this type of group could become a basic program within the agency. Involvement of the care givers could also then become more of an expectation from the agency.

There is a need to provide some ongoing focus for the children who participate in such groups, because of the need for a developmentally sequenced approach, and because the needs for children in care change as a result of their placement realities and changes in their circumstances. If this programming became more available through the agency, then variations and combinations of group composition and use of techniques could be attempted. Greater evaluation of the interventions could also occur, perhaps in a longitudinal fashion.

This group experience provided some answers to questions about how effective a group intervention can be in supporting children in care and their care givers with the experiences of separation and loss. It also raised some other questions which need to be further explored. Specific recommendations include:

1. The agency should provide this type of group for its children in care and their care givers in an on-going fashion. Other models should be explored to see if they might be more effective. Examples include: providing the group to children who are at the same stage of placement (e.g., all participants are within their first six months of care, etc.); providing the group at regular intervals for children who remain in care (e.g., 8, 12 and 16

years of age); and offering groups to a wider range of children in care (i.e., different developmental groupings) as the inclusion criteria for this practicum excluded many of the children in care of the agency.

2. There should be expanded opportunities to provide professional development for workers on the impacts of separation for children when coming into care along with methods and intervention to support those children. This group intervention does not replace the need for workers and care givers to continue to provide support and education to children in care. A commitment by the agency (and child welfare system) to meet the needs arising from placing children must be stated and acted upon.

3. Expand the length of group from ten weeks. The experience of this group was that there was more work that could be done when it came time to end the group.

4. Develop a model to involve the care givers for children in care in an educational and supportive group. This could include gaining the participation of the local foster parent association, the agency providing financial and child care support so that its care givers could attend training and support opportunities, and having an open support group for care givers which they could access as needed. The agency should explore the reasons for the discrepancies between care givers' reports (CBCL) and teachers' reports (TRF) of childrens' competencies and problem behaviors to see if this has an impact upon the stress experienced by the care givers.

5. Offer follow up opportunities for the participants of this and future groups. This would help to support the children in developing and maintaining connections to

each other which decrease isolation and provide support.

6. Continue to develop a hand out (booklet, pamphlet) by children in care which includes information which can be provided to children when they first enter care.

Conclusion

This practicum demonstrated an initial group intervention for children in care that shows promise in supporting their needs resulting from coming into agency care and experiencing separation and loss. It provided children with the opportunity to meet other children in care, learning that they were not alone in their feelings. It provided the agency an opportunity to hear from the children it seeks to serve. It touched upon the importance of involving care givers in a parallel process that provides them with information, education and support. It is an important aspect of the agency's overall service delivery to its clients. It supports the goal of the agency to provide the best care possible to the children in its care.

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Appendix A

Referral form: Child's Name: Age/Birth date:

Gender: Grade:

School and Teacher: File number:

Foster parents: Foster siblings:

Phone number: Location of foster home:

Biological Family Parents/Siblings:

Contact between child and biological family: Status:

Reasons child is in care:

Placement history(number of foster homes, previous apprehensions etc.):

Briefly describe:

a) Behaviors/difficulties arising out of child's separation and loss experience:

b) How you see the child fitting into a mixed-gender group, i.e., maturity level, developmental issues, ability to participate in a group process etc?

c) Any specific needs the child may have which should be considered in the group process?

d) How well you see the foster parents being able to participate in the parallel process?

e) How much do you feel the child knows and accepts why they are in care?

Appendix B

The planned goals and objectives for each week's session

Week One: Specific purpose and objectives: To begin forming the group; dealing with anxiety of entering new group; clarifying expectations; to start identifying some of the goals for the group.

Therapeutic considerations to be aware of: all will be anxious, behaviour will reflect the needs of the children in forming new group; starting to check out other people as well as their wanting to commit to the group or not; have to do some selling. One member not there for the first group, use empty chair for her; group can be experts for her next week.

Activities for that session:

1) a) Welcome and snack.; where bathrooms are; how the group will function, warm up, snack, weekly check in, work, play, exit slip, and use of journal.

b) Review goals/purpose of group as identified by the facilitators to date. There will be opportunities for group members to add to the list of group goals as they move into the group process. List some goals (scribe).

c) Why forming a group?(scribe) i.e., not alone, affirmation, dealing with pain, learning from each other, etc.

d) Rules (developed by the group-scribe). Handout paper on what is a safe place

as discussion starter for the developing of rules/structure.

2) Complete Interview sheet. Purpose is to start to get to know each other, starting to verbalize in the group setting. Method: done in pairs, one child interviewing another then reporting back. Need to find out: name, age, area you live in, favourite thing to do, favourite animal, something you dislike the most, how long you have been living apart from your natural family and what do you want from group? Share back to large group.

3) Complete the Piers-Harris Self Esteem Inventory.

4) Play activity: Clap, Click and Pop Game; Bob Game

5) Exit slip. Review and explain its purpose.

Treatment challenges that may arise: Group at pre-affiliation; everyone will be anxious and seeing how they fit in. Alternate your scribes (scribing is getting one of the children to write down the responses from the members). Let others help with the spelling if the scribe asks or the word is unreadable. Draw all members into the discussion gently.

Week Two: Specific purpose and objectives: To continue the group development; work towards more sharing of personal information and feelings; continue to clarify the purpose of the group.

Therapeutic considerations to be aware of: Children need time and support to

be able to share feelings appropriately; too much too early last session. Move the activity session towards the beginning rather then the end as this group needs to warm up more to each other.

Activities for this session:

1) Check in/Circle Time: How was your week? Anything you want to share or ask for input from the group? Anything that last week's group made happen (trigger) for you? Hand out the exit slip prepared for last week and review how it will be used. Hand out their journals, lots of paper and markers around to use. Check with child- who thought, perhaps, that she would be talking to her 'real' mom at the group. Did any one else think that, hope for that? Done with snack.

2) Continue with the warm up theme; as well as the getting to know each other. Pass around a bag of M&M's. Tell everyone to take as many as they want. Once the kids have all the M&M's, tell them that for each M&M they took, they have to say one thing about themselves. For different colours, share different things, e.g., if someone took 10 M&M's (4 red, 6 orange), they would have to say 4 things about themselves, and 6 things they like about school.

3) Review Safe place sheet. Ask them to draw their safe place. Do brief initial guided imagery to help with visualization.

4) Exit slip

Notes: Take your time, encourage thought and accept all answers as likely

valid to the child. If a child shares too quickly, reinforce the place of safety that group is, but be alert to structure the discussion if sharing is in discriminate or a distraction. Have journals on hand to distribute and review process of how they are to be used.

Week Three: Specific purpose and objectives: To continue the group development; work towards more sharing of personal information and feelings; begin to have participants talk to each other about their experience of coming into and being in care.

Therapeutic considerations to be aware of: Children need time and support to be able to share feelings appropriately; continue to move the activity session towards the beginning rather then the end as this group needs to warm up more to each other. Support the participants to talk to each other more.

Activities for this session:

1) Check in/Circle Time: Introduce concept of temperature check, which is a scaling of hot (Great)- to cold (Lousy). Help them to share and elaborate upon their measurement. Provide child with copy of the Piers-Harris which he asked for. Done with snack.

2) Continue with the warm up theme; as well as the getting to know each other.

1. Split the group into pairs. Each pair will have 30 seconds to find 5 things they have in common. At the end of 30 seconds, put 2 pairs together and give the foursome a minute to find something all 4 have in common. Finally, each group

can present the list of things they have in common.

2. Try the Human Knot.

3) Have the participants draw a picture of their foster family, i.e., who is in it? Have them talk in pairs about their pictures. Discussion: What is a foster family? Scribe 5 words that describe a foster family, do a Word Splash on the flip chart. How is a foster family the same or different from your birth family? Chart this if people seem ready. What is it like to live with a foster family? Done in pairs as interview style.

4) Exit slip, changed a bit, took out 'important'. Need to put more effort into exit slips; Caroline and Dave to write comments for each week so the participants will start to use the journals more if they are interested in what is being written. Perhaps able to start more of a dialogue.

5) Letter to Fps. Discuss moving start time ahead 15 minutes. Two children need to leave at 5:40.

Week Four: Specific purpose and objectives: To continue the group development; work towards more sharing of personal information and feelings; begin to have participants talk about their experience of coming into and being in care; specifically today to talk about social workers and their role in the child's life.

Therapeutic considerations to be aware of: Children need time and support to be able to share feelings appropriately. Support the participants to talk to each other

more.

Activities for this session:

1) Check in/Circle Time: Continue to use the concept of temperature check. Help them to share and elaborate upon their measurement. Review last week's exit slips. What did they write? Also hand out the two word splashed they had created. Done with snack.

2) Avoid activities which involve touch as this group seems to resist that a bit, i.e., along gender lines. 1) Razzle Dazzle - where we form two lines and follow a cris cross pattern of mimicking the first person's actions, which are slow dramatic motions.

2) Bob game, which we played week 1 and the kids liked.

3) Pick up on last week's discussion of the role of the social worker in their lives. Participants have expressed mixed feelings towards their worker, as well as one child was getting a new worker. Led to exploration of the number of workers the participants have had, reasons why workers change, feelings about this and the role that social workers have. Have participants break into pairs to conduct interviews.

Discussion: What is a social worker? 5 words that describe a social worker- do word splash on the flip chart. Role of social worker, do picture which demonstrates the connection of the social worker to the biological and foster families. May bring up issues about why I entered care? Going to court, understanding court; feelings towards the social worker for taking them away from their family or for

protecting them. Have each child begin their Time Line charts and mark on it the different social workers they have had.

4) Exit slip

Week Five: Specific purpose and objectives: To continue the group development. It is apparent that the kids know why they are there now as there was less distraction last week. Continue to work towards more sharing of personal information and feelings. Begin to have participants talk about their experience of coming into and being in care; specifically today to pick up on last week's sharing around pieces related to Birth Family.

Therapeutic considerations to be aware of: Support the participants to talk to each other more. As participants share more of their own story want to support and encourage others to listen empathically.

Activities for this session:

1) Check in/Circle Time:

2) Weather is nice, so perhaps go outside and play Human Pinball.

3) Content/ Discussion: Issues raised last week: One child's Internal Planning Meeting (IPP) in which her grandfather said some things which upset her. Review the purpose of the IPP and the form and its different sections. Generate discussion around Birth Families, i.e., contact with Birth families, who is in your birth family, mixed feelings etc.. Another child sharing about how confused she is about what to do. She feels like she has a choice over whether she goes to live with her father; her mother or

to stay in care. She talked a bit about court and her experience. She reflected the dilemma kids have about loyalties; hopes for their parents to be able to care for them; struggling with accepting the limitations of her parents as represented to her by her social worker and experienced first hand. Try to help her understand the role of the judge in making this decision. Explored in the group the concepts of Permanent status vs. Temporary. Further explore the role of the social worker as a connection to birth and foster families for the child.

4) Exit slip

Week Six: Specific purpose and objectives: To continue the group development as they are heading towards why they are in care and their feelings related to that.

Therapeutic considerations to be aware of: Children need time and support to be able to share feelings appropriately. Support the participants to talk to each other more. As participants share more of their own story want to support and encourage others to listen empathically.

Activities for this session:

1) Check in/Circle Time: Watch you don't congratulate too much over a high day.

2) Try Charades to pick up on some of the dramatic flair that some of the participants are displaying. Make it fun, perhaps reward for getting it right.

3) Birth Family: Need to continue talking and sharing about birth families. While we talk, have the participants draw a picture of their Birth Family Some issues which have been raised to date in regards to birth families:

a) Different levels of contact and involvement between kids and their birth families. There may be reasons for that. What are some of those reasons? Risk factors, court ordered, distance (physical and emotional), and time.

b) Different feelings about and towards Birth family. Some feelings identified so far: anger about being in care, and not being able to look after them, confusion about where you want to live; mixed feelings about Birth Family, excitement over a visit or a package from Birth family, sadness about not seeing a brother, or a parent for a long time.

4) Interview: focus upon birth family. Share back and do word splash on Birth Family.

5) Continue their time line chart. Have them put some basic information on it, birth date, current age, when they entered their current foster home, when they got their current worker, what they did last summer during school holidays.

6) Exit slip. Hand out letter for home.

Week Seven: Specific purpose and objectives: Continue exploring feelings towards Birth Families. Support the participants in telling their story of coming into care.

Activities for this session:

1) Check-in/circle time

2) a) Review:

- How coming into care affects kids.(Feelings/symptoms- scribe)

- How coming into care affects Families.(Feelings/symptoms- scribe)

- Why kids get taken into care.(scribe)

- What kinds of homes/placements do children go to live in.(scribe).

- Different ways that children come into care. Related to why they are in care.

- Role of the agency, worker, and court.

3) Trust Walk. Done in pairs. Spend some time preparing for the activity. Talk about Trust, etc. In pairs, one blindfolded, the guide then takes their partner to an area, i.e. a tree or part of the fence etc. The blindfolded person touches the tree, trying to visualize what it looks like, then is brought back to middle, blindfold is removed and then have to try and locate their tree etc. Group members may be reluctant to be blindfolded and led, allow them to lead another or to watch, then may be willing to try.

4) Interview each other: focus upon birth family. Getting to the issues about why they are in care. Have each group report back. Last week, did word splash, some of

the words used were very incongruent with what had been shared.

5) Work on their time line chart. Have them put some basic information on it; add brothers or sisters coming into or leaving the family; current school, previous schools; places, towns you have lived in.

6) If time, perhaps put information in form of Geno-gram.

7) Exit slip

Notes: Utilize structured questions which are also open-ended, i.e. How old were you when you came into care? Where were you living? What else do you remember? Observe what other members are doing while they listen to each other.

May take more then one week. Recognize defences of denial and repression- don't take away too early! Be prepared for a full range of reactions, depending upon the child's context and reasons for coming into care. Focus upon feelings.

Week Eight: Specific purpose and objectives: The group's purpose is evolving; work towards more sharing of personal information and feelings; begin to have participants talk about their experience of coming into and being in care; continue to support discussion around birth families; heading towards why they are in care and their feelings related to that; appropriate sharing with the group is happening.

Therapeutic considerations to be aware of: Support the participants to talk to each other more. As participants share more of their own story want to support and encourage others to listen empathically.

Activities for this session:

1) Check in/Circle Time: Perhaps ask the participants for a brief review of last week; in particular the sharing which occurred around birth families; some fantasy sharing around going to live with birth families; experiencing of loss of birth families/ loss of "ideal families".

2) Chart the reasons they came up with on why kids come into care.

3) Initiative Task- Rubber band construction project. 9 strings are tied to a strong elastic band. A bag of objects is dumped out; using only the rubber band tool, the group tries to build a monument out of the objects. This is done without talking. Note how the group works together; who takes charge? who follows?; all have to participate or the tool doesn't work; how did members communicate with each other. Use these to debrief the experience.

4) Birth Family: Need to continue talking and sharing about birth families.

Discussion: What do we get from our birth families? (Seeking to get some of the positives out; do it in a brainstorming way); e.g., name; life etc., hair color, looks, body shape and size etc., a love for something, ie- music or the outdoors, brothers, sisters, and extended families. Complete Family Crest for their journal.

5) Work on their time line chart. Have them put some basic information on it. Add brothers or sisters coming into or leaving the family; current school; previous schools; places, towns you have lived in; loss of family members, pets etc.

6) If time, continue work and discussion on placement Geno-gram.

7) Exit slip

8) Take group picture. Start discussion about the group coming to an end. Hand out letter for home.

Week Nine; Specific purpose and objectives: As the group draws closer to the end, start preparing for termination. Will also be important to give the participants opportunity to discuss or raise issues that they need to raise before the group closes. Anticipate some behaviours associated with entering into termination; i.e. resistance to terminate. Continue to work towards more sharing of personal information and feelings

Activities for this session:

1) Check in/Circle Time:

2) Hand out the sheet with the reasons they came up for kids being in care.

Discussion: The focus of the reasons why kids come into care is on the parents' behaviour; not the child's. Reinforce that it is not the child's fault.

Explore why kids may think it is their fault: Do brainstorming in small groups: e.g., blamed by parent, or a friend says something at school etc.; feel different, angry, sad, frightened; other sibs left in home, so it must be them; believe it was their behaviour, ie. Breaking a window, that led them to be in care. They were 'bad', therefore they were put in care.

Concept: Care is not a punishment; maybe see other kids in their foster home, or group home, who did go home; others? Chart this information:

3) Play Activity: Tiger Babies. play over at the park.

4) Discuss: Feelings about the group coming to an end. Wind up party. Hand out letter for home.

5) Exit slip

Week Ten: Specific purpose and objectives: Last group meeting today. Everyone seems ready to end. Will also be important to give the participants opportunity to discuss or raise issues that they need to raise before the group closes. Anticipate some behaviours associated with entering into termination; i.e. resistance to terminate.

Therapeutic considerations to be aware of: Termination session; try to keep positive and hopefully help participants to solidify the bridges and connections they have made.

Activities for this session:

1) Check in/Circle Time:

2) Pushes and Pulls of being in care: Concept that coming into care means change; changes can be seen as positives/negatives; losses and gains; we are going to look at the changes in terms of pushes and pulls; gets away from any value loading; even

though the kids will see it as such.

3) Piers Harris: Have the kids complete the post test.

4) Review with the kids the last ten weeks; ask them what would have been helpful; we want to offer this group to other children and their ideas would be helpful.

5) Hand out group pictures, autographs?

6) Hand out posters.

7) Play Activity: Let them choose something;

8) Wind up party: Pizza and soft drinks. Talk about summer plans and the idea of maybe getting together in the fall.

Appendix C

Consent Form for the legal Guardian:

Practicum on the Separation and Loss Experiences of Children in Care.

This practicum is about the separation and loss experiences of children who are in agency care and the experiences of their care givers in meeting the needs of these children.

The purpose and benefits of this practicum are to:

1. Support children and their care givers in dealing with separation and loss experiences when coming into care.

2. Improve care givers' understanding of children's separation experiences when coming into care.

3. Improve agency practice in responding to and supporting children in their experience of entering care.

The children involved will participate in a ten week support group which will occur at the Family Resource Center. Their participation will entail a commitment to attending all the sessions, completing a self esteem inventory at the beginning and end of the group and in being an active participant in the group process. A child's involvement in the group process may result in his or her addressing several difficult emotional issues which can result in their re-experiencing pain and loss. This is the

core of the group experience and each child will be supported in doing this by the other group participants, their care givers and the group facilitators.

The care givers will also be asked to participate in the practicum through: (a) supporting their foster child's involvement in the group intervention; (b) participating in a parallel process for care givers which will involve interviews and the sharing and discussion of written material; and (c) completing two standardized measures which will be used to evaluate the effectiveness of this group intervention. I will also be approaching the child's teacher to complete a standardized measure on the child before and after the group intervention.

Participation in this practicum is voluntary. No gain or penalty will result from a decision about participating in this practicum. Participants may refuse to answer any question. They also have the right to end their participation in the practicum at any time without penalty. The need for confidentiality and anonymity will be respected within the guidelines of required reporting. Any information which could identify participants will be excluded when the findings are written. While confidentiality will be assured it may be possible for someone within the agency to determine identities given the small population I am working with in this practicum.

The group intervention sessions will be video taped and these tapes will only be viewed by the group facilitators and the practicum supervisors for educational and supervision purposes. These tapes will be erased upon completion of the practicum. A benefit of participation in the practicum is that there will be opportunities to contribute to

any recommendations for changes to the services to children in care and their care givers which reflect the needs arising from coming into care and the experience of separation from natural parents. The agency may have a copy of the summary of findings from this practicum, if you wish.

If you have any questions about anything related to your agency's participation in this practicum, please ask. I can be reached at 726-6144.

Sincerely,

Dave McGregor

I have read and understood the information above and give my consent, on behalf of the children who are wards of this agency, to participate in this practicum.

Signature: _____ Date: _____

Name (please print) _____

Appendix D

Consent Form for the foster parent(s):

This practicum is about the separation and loss experiences of children who are in agency care and the experiences of their caregivers in meeting the needs of these children. You, as their foster parent are being asked to participate in the practicum through: (a) supporting your foster child's involvement in the group intervention; (b) participating in a parallel process for care givers which will involve interviews and the sharing and discussion of written material; and (c) completing two standardized measures which will be used to evaluate the effectiveness of this group intervention. Also, your comments and suggestions are welcomed and will be incorporated into the overall discussion of the practicum.

My name is Dave McGregor and I currently am a Family Services supervisor at the agency. Through this role I may already have had contact with you. This practicum is part of the requirements for the completion of my Masters of Social Work degree.

As part of the interviews, I will ask you about your experiences in caring for foster children; in supporting them through their experiences of separation and loss; and in meeting their emotional and behavioural needs while in your care.

Your participation in this practicum is voluntary. No gain or penalty will result from your decision about participating in this practicum. You may refuse to answer any question. You also have the right to end your participation in the practicum at any time

without penalty. Your need for confidentiality and anonymity will be respected within the guidelines of required reporting. Any information which could identify you will be excluded when the findings are written. While confidentiality will be assured it may be possible for someone within the agency to determine identities given the small population I am working with in this practicum.

A benefit of your participation in the practicum is that you will have an opportunity to contribute to any recommendations for changes to the services to children in care and their care givers which reflect the needs arising from coming into care and the experience of separation from natural parents. You may have a copy of the summary of findings from this practicum, if you wish.

If you have any questions about anything related to your participation in this practicum, please ask. I can be reached at 726-6144.

Sincerely,

Dave McGregor

I have read and understood the information above and give my consent to participate in this practicum.

Signature:_____ Date:_____

Appendix E

Outline for Foster Parents:

The Separation Experiences of Children in Care

Goals/Purpose of the group: To support children and their foster parents in dealing with separation and loss experiences resulting from the child coming into care. Specifically:

- to validate the expression of their feelings;

- to help children to think about their experience in ways that are less destructive to their self-image by assisting them to reduce their sense of responsibility and guilt;

- to teach children coping skills to more appropriately express their needs, including:

- assertiveness, anger management, relaxation, identifying and verbalizing their feelings and past experiences, social skills, and problem solving.

Major Themes to be explored in group:

1) About coming into care.

2) About families, and reasons for coming into care.

3) About feeling different.

4) About foster Parents/Families.

5) About school, teachers and friends.

6) About the system, people and policies.

Three measures will be used to evaluate the effectiveness of the group intervention:

1) Auchenbach Child Behaviour Checklist(CBCL/4-18)-which foster parents complete to identify a child's competencies and behaviours. Also the Teacher's Report form(TRF) will be completed by the child's teacher.

2)Abidin's Parenting Stress Inventory(PSI)- This measure will be completed by the foster parents and is used to identify the interaction of the effects of stress upon parenting behaviour.

3) Piers-Harris Children's Self Concept Scale: This is a self report measure, completed by the children which measures their feelings about themselves.

Expectations of foster parents:

Before group:	Meet with group facilitators
	Complete CBCL(4-18)
	Complete PSI
During Group:	Ensure child attends group
	Participate in parallel process
After group:	Complete CBCL
	Complete PSI
	Complete qualitative evaluation.

Foster Parent package:

1. Outline of group intervention
2. Letter of Consent
3. CBCL
4. PSI

Appendix F

Letter to child's teacher

April 15, 1998

Dear *teacher's name*,

My name is Dave McGregor, and I am a supervisor for Child and Family Services of Western Manitoba. I am writing to you as one of your students will be participating in a group I am facilitating for the agency as part of my Masters practicum. The student's name is *student's name*, and as you likely know *he or she* is a ward of Child and Family Services. *Child's name's* social worker and foster parents have referred *him or her* to the group and *he or she* has agreed to participate. The goal of the group is to help support children in coping with their experiences of separation and loss associated with coming into agency care. The group will be running for ten weeks, from now until the end of June. It will be on Tuesdays after school.

To help evaluate the effectiveness of this intervention, I am asking that you as *child's name's* teacher, complete the enclosed Teacher's Report Form (TRF) which is part of the Child Behaviour Check List (CBCL). This is a standardized measure which is often used to evaluate the effectiveness of treatment programs for children. The form is fairly straight forward and should only take ten to fifteen minutes of your time. I will also be approaching you at the end of the group to complete the measure again. It is very

important to gather information from significant people in the child's system, therefore I will be gathering data from the child, the foster parent(s), and from you, *his or her* teacher in order to help evaluate this intervention. All information gathered will be confidential and no identifying information will be used in the writing of the practicum.

Thank you for your anticipated co-operation. Enclosed is the TRF and an addressed, stamped return envelop. Please return to my by April 24th. I will mail you the follow up TRF in June. If you have any questions, please don't hesitate to call me at *phone number*. For your information, Child and Family Services has signed an informed consent on behalf of all the children for their participation in the practicum.

Sincerely,

Dave McGregor, RSW

Appendix G

Exit Slip ***Date***:

Today in group we:

- talked and shared about:

- made:

- played:

Today, one of the things we learned was:

A question I have is:

Response:

Appendix H

Foster Parents' Evaluation Form:

1) How do you feel your foster child did in the group?

2) Was there anything specific that your foster child took from their participation in the group?

3) Did you observe any changes in your foster child's behaviour or attitude about being in care?

4) Do you have any suggestions or comments for future groups?

5) What would have been helpful for you as foster parent in dealing with behaviour associated with coming into care and dealing with issues of loss or separation?

Appendix I

Comparisons of the group's mean *T* scores for the CBCL at Pretest and Posttest to that of the normative samples (Auchenbach, 1991, pp. 29 & 54)

For boys, 12-18		***Normative Sample (n= 564)***		***Group (n = 2)***	
				Pretest	***Posttest***
Total competence: *T* score:		**Mean**	50.3	39.0	40.0
		SD	9.7	0	1.4
		SE	.5	0	1
Internalizing:	*T* score	**Mean**	50.3	61.5	60.5
		SD	9.8	4.95	4.95
		SE	.4	3.5	3.5
Externalizing:	*T* score	**Mean**	50.1	67.5	68.5
		SD	9.8	2.1	2.1
		SE	.4	1.5	1.5
Total Problem:	*T* score	**Mean**	50.0	67.5	69.5
		SD	10.0	2.5	4.5
		SE	.4	2.5	4.5

For girls, 12-18		*Normative Sample (n=604)*	*Group (n=3) Pretest*	*Posttest*
Total competence:	*T* score	Mean 50.4	37.67	42
		SD 9.8	8.15	14.7
		SE .4	4.7	8.5
Internalizing:	*T* score	Mean 50.0	60.3	57
		SD 10.0	9.7	8.5
		SE .4	5.6	4.9
Externalizing:	*T* score	Mean 50.2	63.3	62
		SD 9.8	11.59	12.1
		SE .4	6.69	7
Total Problem:	*T* score	Mean 50.0	66.0	62.6
		SD 10.2	13.0	10.0
		SE .4	7.5	5.8

For girls, 4-11		*Normative Sample (n=619)*		*Group (n=1)* Pretest	Posttest
Total competence:	*T* score	Mean	50.2	39.0	38.0
		SD	9.8	--	--
		SE	.5	--	--
Internalizing:	*T* score:	Mean	50.0	76.0	65.0
		SD	9.7	--	--
		SE	.4	--	--
Externalizing:	*T* score:	Mean	50.0	74.0	77.0
		SD	9.6	--	--
		SE	.4	--	--
Total Problem:	*T* score:	Mean	50.1	74.0	75.0
		SD	9.9	--	--
		SE	.4	--	--

Appendix J

Comparisons of the group's mean *T* scores for the TRF at Pretest and Posttest, to that of the normative samples (Auchenbach, 1991, pp. 22 & 43).

For boys, 12-18		***Normative Sample (n= 309)***		***Group (n=3)***	
				Pretest	***Posttest***
Adaptive Function:	*T* score:	Mean	50.2	44.0	41.3
		SD	8.7	2.0	2.5
		SE	.5	1.2	1.5
Internalizing:	*T* score:	Mean	50.5	50.3	50.6
		SD	9.4	4.0	4.9
		SE	.5	2.3	2.8
Externalizing:	*T* score:	Mean	50.7	51.6	51.3
		SD	9.5	10.2	10.8
		SE	.5	5.9	6.2
Total Problem:	*T* score:	Mean	50.3	54.6	54.6
		SD	10.1	1.5	1.5
		SE	.6	.8	.8

For girls, 12-18		*Normative Sample (n=369)*		*Group (n=3)* Pretest	Posttest
Adaptive Function:	*T* score:	Mean	50.1	38.3	41.3
		SD	8.7	4.2	5.6
		SE	.5	2.4	3.3
Internalizing:	*T* score:	Mean	50.3	48.6	51.6
		SD	9.4	6.35	7.0
		SE	.5	3.6	4.0
Externalizing:	*T* score:	Mean	50.7	56.6	55.0
		SD	8.9	6.8	11.3
		SE	.5	3.9	6.5
Total Problem:	*T* score:	Mean	50.3	55.6	54.6
		SD	10.0	7.02	9.1
		SE	.5	4.05	5.2

For girls, 4-11	*Normative Sample (n=379)*	*Group (n=1)*	
		Pretest	*Posttest*
Adaptive Function: *T* score	Mean 50.0	38.0	35.0
	SD 8.7	--	--
	SE .5	--	--
Internalizing: *T* score:	Mean 50.3	74.0	68.0
	SD 9.5	--	--
	SE .5	--	--
Externalizing: *T* score:	Mean 50.7	57.0	57.0
	SD 8.8	--	--
	SE .5	--	--
Total Problem: *T* Score:	Mean 50.2	68.0	67.0
	SD 9.8	--	--
	SE .5	--	--