Kid's Power!

A Group Intervention for Children in Families Where There Is Substance Abuse

By Sara Yager

A practicum submitted to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Masters of Social Work

University of Manitoba

Winnipeg, Manitoba

October 2004

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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Where There is Substance Abuse

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

Of

Social Work

Acknowledgements

Table of Contents

Acknowledgements	ii
Abstract	ix
Introduction	10
Literature Review	17
The Scope of the Problem	17
Moderating Variables	21
Social Learning, Competence and Nature vs. Nurture	22
Treatment Approaches	27
Psycho-educational Theory	27
Cognitive Theory	28
Solution-focused Theory	35
Narrative Theory	39
Individual Versus Group Intervention	44
Group theory	44
Alternatives in the Literature	51
Design of Intervention	**56**
Objectives	57
Group design	59
Group setting	61
Recruitment	63
Group structure	64
Group goals	66

Group format 67

Outline of Group Modules 70

Session 1: Getting to Know Each Other 70

Objectives 71

Introductions 71

Housekeeping 71

Activity one 72

Activity two 73

Check-out 73

Session 2: Addictions as a Disease 73

Objectives 73

Check-in 74

Housekeeping 74

Activity one 75

Activity two 75

Check-out 75

Journal writing 75

Session 3: Families and Addictions 75

Objectives 75

Check-in 76

Housekeeping 76

Activity one 76

Activity two 77

Check-out	77
Journal writing	77
Session 4: Families and Addictions (Part 2)	77
Objectives	78
Check-in	80
Housekeeping	80
Activity one	79
Activity two	79
Check-out	79
Journal writing	80
Session 5: Coping With Problems	80
Objectives	80
Check-in	80
Housekeeping	80
Activity one	80
Activity two	81
Check-out	81
Journal writing	81
Session 6: Changes	81
Objectives	81
Check-in	81
Housekeeping	81
Activity one	81

Activity two 81

Check-out 83

Journal writing 83

Session 7: Choices 83

Objectives 83

Check-in 83

Housekeeping 83

Activity 85

Check-out 85

Journal writing 85

Session 8: Self Care/Good Bye Ceremony 85

Objectives 86

Housekeeping 86

Considerations for Facilitator Selection 86

Selection of Membership/Preparation for Group Process

A Comparison 93

Value of Chosen Model of Intervention 97

Client Profiles 106

Attrition, Attendance and Participation 112

Tuesday Sessions 113

Thursday Sessions 135

Evaluation 150

Self Anchored Scales 151

Therapists rating scales 151

Caregiver rating scales 153

Standardized Measures 153

Logs 154

Data Analysis 155

Pre Test Post Test Analysis 157

Rosenberg Self Esteem scale 157

Self anchored rating scales 159

Facilitator versus self perception 161

Log 163

Consumer satisfaction and feedback 164

Closing Interviews 165

Variables Impacting on Results 166

Learning Objectives 168

Implication for Future Social Work Practice 172

References 178

Appendix **A** 187

Appendix B 189

Appendix C 191

Appendix D 192

Appendix E 193

Appendix F 194

Appendix G 195

Appendix H 197

Appendix I 198

Appendix J 200

Appendix K 202

Appendix L 204

Abstract

This practicum describes a small group intervention with latency aged children of substance addicted caregivers. Treatment focused on providing an intervention option supportive to children and their families, building up behaviors contributing to resilience. The goal was to minimize potential for continuation of dysfunctional lifestyles and substance abuse.

The group intervention was short term, consisting of two groups, run concurrently on separate days. Each session was one and half-hours in length. This writer and one other facilitator, along with a variety of volunteer support staff co-facilitated the sessions.

Group treatment objectives were to decrease maladaptive coping behaviors in the participants while increasing feelings of self worth. Further identified goals were to develop, implement and evaluate an intervention that assisted participants in learning positive alternative means of coping and an increase in their self esteem. The intent was to give the group members healthier opportunities to break the cycle of dysfunction as adults, while remaining connected with their family of origin.

An extensive literature review was undertaken on children of substance abusing caregivers and its effects on the children. The evaluation utilized a pretest/posttest group design. Clinically significant results at $p=.05$ level were noted for group members in the area of increased self esteem. Both groups stayed constant or increased in positive effect. Facilitator documentation provided qualitative perspectives validating these patterns. Both caregivers and the participants shared that they would highly recommend Kids Power! to other children.

INTRODUCTION

Substance abuse is one of the most common reasons that families become involved in the child welfare system. Eighty-five percent of families involved with protection services struggle with addiction related issues (L. Dorge, Abuse Intake Supervisor, Winnipeg Child and Family Services, personal communication, September 18, 2003). Substance abuse can be a significant precipitating factor in the chronic neglect of children, as well as physical, emotional and sexual abuse of children. Increasing numbers of children suffering the harm of substances while in the fetal stage (FAS/ FAE) are coming to the attention of child welfare authorities. Overall, impact of addictions in the family often lead to children being at serious risk and ultimately removed from their homes and placed in alternative care arrangements.

Historically, the child welfare system has focused on assisting parents to deal with their addictions in order to alleviate risk. Little has been done to assist the youngsters who have to cope with addicted caregivers. Child welfare personnel tend to lack direct knowledge of interventions which might help children improve their chances of survival and ultimately assist them in becoming healthy adults.

Support to children who live in addicted families is limited and there seems to be little to no understanding within the child welfare system of the benefits to providing children with services separate from their families. In light of this fact, very few services exist for children of addictions (COAs) whose family is not in treatment. An especially neglected group in this regard is elementary aged children over the age of seven years but who are not yet teenagers.

The following intervention was prompted by a growing awareness that latency aged COAs were falling through the service cracks in the child welfare system due to a lack of both resources and knowledge of innovative and effective interventions.

Many COAs tend to experience numerous living situations during the course of their childhoods. Often they are moved between homes to live with other family members and many are also in and out of foster care. As a result, a lot of of these children develop significant behavior problems that tend to become more acute as they grow up. The lives of these children are further impacted by the related effects of inconsistent, disrupted and often chaotic parenting. Some may be offered minimal interventions while they are still attending school. Given the unpredictability of the primary caregivers for these children, assistance at home is often ineffective because of inconsistent parenting amongst the numerous caregivers.

Schools and other collaterals may grow frustrated and annoyed at what appears to be the parents' lack of support for their children and the child welfare system's lack of impetus to apprehend the child and solve the problem. While well-intentioned, there does appear to exist a misguided belief that removing children from their families and finding them an alternative home is the answer. Child welfare history shows the contrary to be true.

Child welfare agencies do a poor job of replacement parenting. Because of their family histories, COAs often mature lacking the inner resources or life skills needed to make different choices than their caregivers. Because of the support they lack, COAs become increasingly isolated from collateral community resources that are for the most

part equipped to offer them some assistance, further increasing their risk to abuse substances as adults.

The reality of the child welfare system's ability to offer COAs anything but basic care is minimal, with the exception of very extreme situations. Removing children from their homes, no matter how dysfunctional, is often not the solution. Indeed, it rarely is. Apprehension is often temporary, and when it is permanent in the legal definition, the reality is quite the opposite. Frequently children relocate to extended family members or friends through the court system, and ultimately return to the care of their birth family by default. Inevitably, the trend is that children tend to return to their families of origin, whether as children or as young adults.

Children need to be equipped with the skills and understanding that they can live and do things in a way different from their addicted caregivers. Without intervention, the level of functioning and ability to maintain minimal safety standards for children in these homes will continue to flounder. If not challenged, future generations of children will be negatively affected by substance abuse, in any number of direct or indirect ways, including abusive, illegal and neglectful behaviors inflicted on others and passed on to other generations. Further, the situation for COAs becomes complicated as schools, communities and peers quickly follow suit in rejecting these children based on their behaviorally and emotionally challenging presentation.

Often what is available to the children is offered only in conjunction with, or conditionally upon, the primary caregivers' acceptance of services. There is a dire need to provide service to children whose parents cannot identify their own problems and therefore cannot identify their children's needs. There is some availability for

independent support groups for children, exclusive of their parents' status in treatment/recovery. However, these are reliant on the child and/or family members to access the resource. These resources are limited in Manitoba to adolescents such as Alateen. Interventions need to start well before the child reaches adolescence. Preadolescents are impacted too and by the time they reach adolescence they may not be candidates for services. Preteen resources are scant and there is the added problem of the child's ability to access them.

Highlighted in this document is the need for better understanding of the mediating variables for COAs. Particular attention is given to those factors that may positively affect the survival skills of COAs. The individual who is a COA is not destined to become an addict, or even dysfunctional, as an adult. There are many contributing factors, such as environmental and genetic factors, that contribute to how COAs mature into adulthood. A COAs dysfunction is often the result of a lack of coping skills, lack of support, and poor self-esteem. It must be frustrating for the latency aged COA attempting to access resources. Latency aged COAs are often not prioritized on play therapy waiting lists, nor afforded counseling opportunities because they do not present as being in crisis. However, the earlier a child begins a preventative intervention, the more positive the results in self-esteem and sense of locus of control. This interminable period without support begets a sense of urgency for the COA to reach the age of 12, when they will qualify for Alateen. Clearly, a latency aged COA is left in a state of limbo because of nonexistent resources.

A group resource for latency aged COAs is a first step in balancing between the stresses of being a COA with the ameliorative protective factors. (Krovetz, 1999). In

providing a group resource program, opportunity is offered as part of the process of COAs dealing more effectively with stressors (Roosa, Genheimer, Short, Ayers & Shell, 1989), while offering a supportive and caring environment, doubly serving to reduce risk (Easley & Epstein, 1991).

This practicum explored effective interventions for behaviorally acting out COAs, aged 8-11 years old, who did not otherwise have an opportunity to receive support. This practicum was designed to provide an intervention option supportive of children and families in an effort to establish a network of future connections in the outside world, and to introduce the skills with which to access these resources when needed. Intervention with this population was initiated in order to build up behaviors contributing to resilience and to minimize the potential continuation of dysfunctional lifestyles and addiction. Early intervention offers this population an opportunity to develop the skills and personal resources needed. It also ensures that alternative sources for nurturing and support are in place, thus, decreasing the likelihood of future dysfunction.

Goals to be achieved through the group work included decreasing maladaptive coping behaviors in children while raising feelings of positive self worth, and to develop, implement and evaluate an intervention that assists these children to learn alternative, positive means of coping while increasing self esteem. An additional goal for the writer was to practice advanced clinical social work skills in a group setting.

The intervention developed was an eclectic approach that utilized a psycho-educational group format along with cognitive restructuring techniques, solution focused and narrative therapy approaches. The group design itself was based on small group theory. The group provided participants with an avenue for understanding substance

abuse, decreasing acting out behaviors, examining feelings, addressing alternative coping skills and learning about supports while reducing isolation and stigmatization and practicing healthy problem solving and coping skills.

In addition, mutual support, education and improved interpersonal relationships were encouraged. The group ran for eight consecutive weeks, with each weekly session being an hour and a half in duration. Each session addressed issues faced by COAs, with the goal of increasing the COAs self esteem and coping skills in an effort to assist them in negotiating their adolescence into successful adulthood, free of the dysfunction thwarting many COAs.

Overall, the objective was to give children healthier opportunities to become adults who will be able to break the cycle of dysfunction while remaining connected to their family of origin. It was proposed that a child with some sense of their own value and some sense of age appropriate realistic control would tend to assert and advocate for oneself within the world. The initiation of this intervention bridged a gap in child welfare service for this population while generating valuable data and clarifying the effectiveness of the group intervention for this population. It also provided information for relevant areas of future child welfare involvement.

Specific objectives for the group intervention were to provide education and support to children of alcoholics who are experiencing behavioral difficulty. The intervention design emphasized understanding alcoholism and addictions to help COAs understand their behaviors as responses to contexts that are choices. COAs were encouraged to take responsibility for their actions. This program emphasized learning impulse control, self-monitoring techniques and coping mechanisms to alter and control

behaviors, and to facilitate COAs ability to develop healthy coping strategies for their situations, as well, to build healthy self-esteem in COAs and help them practice positive social skills.

The effects of the intervention were evaluated using the Rosenberg Self Esteem Scale (RSE) and several self anchored scales completed by the group facilitators, the group members, and the caregivers respectively. These scales were administered pre and post group. The resulting data was supplemented with more subjective data, including a post group satisfaction questionnaire, as well as the facilitator's progress notes. Taken together, these data sources were analyzed to provide an inclusive and extensive view of the impact of the intervention.

Learning objectives for the practicum from the writer's perspective as a Master of Social Work student included to broaden and practice my clinical social work skills with small groups and to become more familiar with cognitive theory and group work theory, particularly as these perspectives pertain to children of alcoholic/addictions and to increase proficiency in using clinical assessment measures to further enhance my clinical practice.

LITERATURE REVIEW

The Scope of the Problem

According to the Addictions Foundation of Manitoba (AFM) (2000) the estimated alcohol addicted population in Canada is approximately 635,000. Given that it is estimated that there is an average of 2.5 children per Canadian family, it could be predicted that there are currently about 1.5 million, or 1 in 5 children who are living with an alcoholic parent (AFM, 2000). Thompson (1990) suggests that historically child welfare agencies have under diagnosed the numbers of families affected by alcohol abuse, and subsequently underestimated how many children are affected by addiction. This suggests that many families have been treated for problems that are really underlying symptoms of an undetected family substance abuse problem (United States Department of Human Health Services (USDHH), (1986). Several reasons exists for this which may include a reluctance to deal with alcohol misuse, professionals feeling they lack the knowledge and skill to deal with alcoholism; and social workers who doubt their right to ask clients about their drinking (Thompson, 1990). Googins (1984) writes that myths, misinformation and moralistic attitudes together with the professional's denial of addictions, parallels the denial of the client. This "wall of denial" prevents adequate treatment of alcoholic families. The statistical implications drawn from this are that the numbers of COAs may be grossly underestimated.

The high rate of birth children affected with FAE/FAS further emphasizes the need for services to these children. The National Association for Children of Alcoholics (NACOA) has estimated that as many as 80% of identified exposed prenatal children of untreated addicted mothers will be placed in foster care in the first year of life (2000).

The intention of foster placement is being "in the best interests of the child", but in reality placement in foster care can increase the risk of future developmental problems including general delays in reaching developmental milestones (NACOA, 2000). It is well documented in the literature (Barth, 1992; Daren, 1986; Howard, et al., 1989) that children with FAE/FAS exhibit any number of physical, cognitive and behavioral challenges. Behaviors vary depending on the child, the degree of compromise affected by prenatal alcohol exposure and the family environment. All children with these behaviors require exemplary patience and parenting skills.

The relationship between substance abuse and child abuse and neglect has been documented in the large proportion of cases seen by child welfare workers. According to the NACOA (2000), 81% of the cases of child abuse involve substance abuse. The relationship between alcohol abuse and violence, as related to lower impulse control, is well recorded and supports this statement. Consequently, not only are COAs at an increased risk of living with extended family for periods of time, they are more likely to enter foster care, have multiple placements and remain in foster care longer (NACOA, 2000).

Historically, child welfare agencies repeatedly respond to this population with crisis-oriented interventions. In an attempt to lower risk and ensure the safety of the children, the focus has been placed on the caregiver seeking treatment. Hastings & Typpo (1984) and AFM (2000) make reference to Alateen and Alatot groups that may address the situation. However, access to these programs is problematic and very few children whose caregivers are not already involved in Al-anon or AA attend (AFM, 2000). Thompson (1990) states that the success rate of forced interventions on caregivers is

negligible, and consequently the same families continue to receive involuntary child welfare services generation after generation while underlying issues do not get addressed. Given the size of this population, and the history of ineffective interventions, it seems obvious that a more accurate perspective on the depth of the problem is warranted. The future social implications of continuing to inadequately service these populations are far too serious to leave the issue unattended.

In articles in 1981 and 1982, Pilat stated COAs become increasingly responsible for adult roles in the family, especially in the emotional absence of the alcoholic parent. Roles undertaken by COAs range from parenting younger siblings to becoming the sexually/emotionally intimate partner of the nonalcoholic parent. This writer, while working in child welfare, has witnessed such scenarios.

The literature offers many insights into COAs and their family life (Dundas, 2000; Menees, 1997; Sher, 1997). Sher suggested that the psychological characteristics of COAs are such that they are at higher risk for psychological disorders both as children and as adults. COAs seem more impulsive in comparison to non-COA populations (Sher, 1997) and were identified as more isolated, thus placing them at a higher risk for low self-esteem (Menees, 1997). These claims were substantiated by the findings that physical and cognitive affective distancing are common means by which COAs cope (Dundas, 2000). This distancing response alleviates destructive conflicts from escalating within the alcoholic family, reducing some stress, but increasing isolation and feelings of low worth. Cognitive and affective distancing challenges cohesion and facilitates other inter-relational impairments amongst the alcoholic family unit.

Adding to this description, Clair and Genest (1987) found that many COAs report hostile feelings towards their parents, experience role confusion, and describe more disruptive and less cohesive family environments. Johnson (2001) qualified this statement in his findings that COAs experience lower levels of functioning (unresolved conflict/low levels of cohesiveness/physical and verbal aggression) and more traumas than non-COAs. This range of effects is consistently noted amongst a wide range of authors, across a variety of COA populations (Johnson, 2001).

Ackerman (1983) considers an "additional adult roles" perspective, which offers a psychosocial framework for understanding how alcoholism affects COAs by disrupting vital parenting functions. The suggestion is that alcoholism interferes with the ability to nurture children and to be consistent in parenting. This results in deficient parenting, thwarting the resolution of stage related crisis (Ackerman, 1983).

Psychosocial theory (Erikson, 1963), takes into account biological, social and life span development. In considering the continuity of attachment, Erikson (1963) speculates that difficulty resolving early psychosocial crises leaves children ill equipped to adapt to more complex crisis later in their life. Hence, when conditions (i.e.; alcoholism) exist within a family unit that may compromise the COAs ability to resolve the stage related crisis, the result is a child without the skills to progress to the next stage. For example, if a caregiver's ability to nurture and be consistent is compromised, the child may not develop a basic sense of trust in others (Erikson, 1963). Failing this, the child cannot be successful in resolutions to their current stage thus potentially impeding their developmental progress (Erikson, 1963).

Moderating Variables

Despite these risks, there is a great number of COAs who emerge from their families functioning as healthy adults, for example, not repeating their family of origin's dynamics (Clair & Genest, 1987; Sher, 1997). Sher (1997) and Jacob & Seilhamer (1990) argue that the actual population negatively affected by alcoholic families is quite small and that many popular portrayals of COAs may be overgeneralizations. Burke & Sher (1988) suggest that common reports of maladjustment in COAs may be partially due to more investigations utilizing samples from clinical populations. This suggests that the samples used in the research on this population are not entirely representative of COAs as a group. This trend needs to be carefully considered when making such generalizations.

The catalyst for this seeming disparity in reported functioning amongst COAs remains elusive. As pointed out by Burk & Sher (1988), there has been little research regarding moderating variables that may account for the wide range of adult functioning in people who are COAs. Clarification of these dynamics to facilitate more effective interventions with this population is essential.

The logical consequence of these traits, as they manifest themselves in COAs, may shed some light on the elusive moderating variables. Rak & Patterson (1996) and Werner (1986) found that COAs may be buffered by traits that contribute to them becoming healthy balanced adults. For example, the quality of the early care-giving environment can lead to positive self-concept and an internal locus of control. Additionally, to create a range of adaptive behaviors there is a need to balance risk factors of parental alcoholism, stressful life events and protective factors in the child and the care-giving environment (Werner, 1986). Paralleling these findings, Roosa, et al

(1989) found that the primary risk factor is stress (i.e.; alcoholism) and the protective factor is a child's self esteem. Consequently, any intervention should focus on having the child deal more effectively with stress (Roosa, et al, 1989).

Social Learning, Competence & Nature vs. Nurture

Social competence, including problem solving, autonomy and development of a sense of future purpose all increase a child's capacity to successfully negotiate life (Krovetz, 1999). Pervasively, these COAs have a more flexible definition of family and what makes one part of a family (Krovetz, 1999).

Krovetz (1999) noted flexibility and openness to alternative definitions of kin expands the range of sources from which a child's needs can be met and developed. The understanding inherent in this creative perspective is that there is more than one way to meet emotional needs. Further, it encourages COAs to continue to "think outside the box" when coming face to face with adversity, a universally beneficial survival skill. Efforts to protect these qualities should include a caring environment, positive expectations and participation (Krovetz, 1999). When these protective factors cannot be accessed within the family/ home environment, interventions with COAs can provide substitute contexts. Doing so facilitates the development of resilience traits in spite of contrary conditions.

An alternative conceptualization of this perspective is Bennett, Wolin & Reiss' (1988) idea of deliberateness. They define the main determinant of one's deliberateness level as the ability to act on a plan. In the process of learning how to be deliberate, COAs learn that they can successfully meet difficult challenges (Bennett, Wolin & Reiss, 1988). Purposeful development of skills that support the development of adaptive behaviors

assist COAs in successfully dodging the negative level of functioning found in a number of COAs.

Easley & Epstein (1991) expanded the notions of Bandura's social learning perspective (1977) when they advocated that any of the non-supporting factors within the family for alcoholic behavior have a strategic role in protecting children. Thus, a goal in preventative efforts should include minimizing disorganization in roles and routines. Families are likely to benefit from treatment that helps to identify and maintain sources of stability in their members' lives (Easley & Epstein, 1991). This should include interventions that counteract disruptive effects of alcoholic behavior and give an identity as a nonalcoholic family; to decrease the probability of COAs having trouble in adult adjustment (Easley & Epstein, 1991).

Burwick and Martin, et al (1988) surveyed literature supporting the belief that ritual preservation (predictability/consistency) and genetic factors seem to have a positive effect on COAs successful transition to resilient adults. The familiar "ritual protecting family", i.e.; families who protect rituals, is identified as being important in COAs ability to defy the legacy of alcoholism. In light of this finding, it is proposed that interventions be geared towards providing identified preventative factors (i.e.; consistency/predictability). Emphasis on model consistency, responding to both adaptive and maladaptive behaviors and enabling children to experience success, is recommended. The theme in Burwick and Martin's (1988) article is one of pessimism towards COAs. The basis of their paper clearly lies in the common "Damage Model" paradigm commonly found in the information on COAs. While the Damage Model structure makes the approach to intervention less appealing, it provides valuable, concrete examples of

how to build qualities of "non transmitting families" into the lives of COAs outside the home. An example is the use of routine, structure and consistency in interactions with COAs.

Researchers Wolin and Wolin wrote about the merit restructuring historical bias, from a negative 'at risk' or a damage model to a positive "resilience model". This simple shift can make a great deal of difference in the support and prevention of COAs succumbing to their legacy (Wolin & Wolin, 1995). Wolin and Wolin encourage the professional to pursue new tangents in assessment.

Jacob and Seilhamer (1990) identify the critical issue in intervening with COAs as the need to clarify the parameters of risk of living in a family with substance abuse issues, specifically, the biological and psychosocial factors mediating vulnerability in COAs. A behavioral systems perspective suggests the need for an exploration of family processes and adjustment capabilities in COAs. The assumption underlying this perspective is that the information gathered defines the degree of risk. Information is then utilized to clarify treatment perspectives.

Paralleling Wolin and Wolin, Jacob and Seilhamer identify methodological as well as conceptual weaknesses in studies that attempt to address the comparison of effects of genetic vs. environmental factors on COAs. Jacob and Seilhamer (1990) attempt to close this gap through offering alternatives. They focus on psychosocial factors that influence COAs, such as ritual preservation.

Many COAs exhibit adequate to superior functioning; maladjustment seems to be situational. The primary effects of alcoholism is the creation of a family environment marked by multiple deficiencies. Filters can temper or magnify the effects of the

environment's ability to mediate healthy child adjustment. All the information reviewed by Jacob & Seilhamer (1990) is consistent and in agreement that there is ongoing association between alcoholic families and strained parent child relationships.

Supporting this perspective, Orenstein and Ullman (2001) suggest that while being a COA is a risk factor in itself, other obviating factors exist that appear to protect COAs to a significant degree. The implication is that "there is nothing inevitable about the transmission of substance abuse..." (Orenstein & Ullman, 2001). In other words, because the parent is an alcoholic does not result in the child growing up as an alcoholic as well. They did conjecture though that the likelihood is greater of children from homes in which the alcoholic is given a great deal of power to become alcoholics themselves. In their observation of the alcoholic's control over the household, the COAs learn that alcohol can make them powerful. Substance abuse provides a solution to the powerlessness engendered by high transmitting families (Orenstein & Ullman, 1994).

Theoretical similarities exist between the studies of Oenstein and Ulman and Wolin and Wolin. However, their research lacks attention to the concept of resilience. It seems that they subscribe to an assumption that COAs are victims of events. Other theorists believe differently. Seilhamer's identification of qualities such as consistency in routine that may decrease risk to the children (1990) suggests direction about which qualities may benefit the participants in the future, and therefore should be considered key to the intervention model.

Steinglass (1987) and McCord (1988) parallel this proposition. Steinglass and McCord, both purport that there is something particular to alcoholic families which enhances the likelihood of transmission of illness, such as one parent holding the other

parent's drinking in high regard. The drinking behavior is allowed to dominate the family to the extent that routines and parenting styles are completely dictated by it. McCord concluded, "...men, whose fathers were alcoholics may have been taught that the behavior was acceptable and part of the male role" (1988). Again, when alcoholism is allowed to become the identity of the family unit there appears to be more negative effects on the COAs.

COAs commonly report chaotic responses by their addicted caregivers. These realities often play themselves out in the lives of COAs and elicit symptomatic behavior in other areas of their life such as school, peers and communication. Examples of these behaviors include inability to focus, aggressive outbursts, difficulty sleeping and regressive toileting. Windle (1996), found that the adverse effects of parental drinking on COAs were related to poor role modeling, parenting skills, marital and family relationships, all leading to problematic outcomes such as poor communication skills, domestic violence and "excessive" parenting methods. Unchanged, these problematic outcomes further lead to internalized problems including depression, anxiety, delinquency and substance abuse (Windle, 1996). This echoes the earlier point that it is often these problematic outcomes that bring families to the attention of child welfare agencies, rather than the cause. For example, it is the behavioral acting out and/or poor physical hygiene that cause child welfare authorities to become involved with alcohol dominated family dynamics and not the alcohol abuse itself. The alcohol abuse is noted once the child welfare authorities are involved with the family.

In summary, the last paragraphs have highlighted the need for better understanding of the mediating variables that have been shown to positively influence the survival skills

of COAs as well as the lack of resources available for those children in the latency aged population. The individual who is a COA is not destined to become an alcoholic, or even dysfunctional, as an adult. Rather, it may be many contributing environmental factors that cause the COA to become a dysfunctional adult. The dysfunctional adult risks a lack of coping skills, a lack of support, and suffers poor self-esteem. These three consequences seem to be the dominate ones found in COAs who later become dysfunctional adults.

Intervention with this population is clearly warranted. Efforts to nurture behaviors contributing to resilience and minimize the potential continuation of dysfunctional lifestyles and addiction should be the focus of any effective treatment intervener. Early intervention offers COAs an opportunity to develop the skills and personal resources necessary to lessen the likelihood of them experiencing future dysfunction in their adult lives. The intervener would want to ensure that alternative sources for nurturing and support are in place to buoy the COA as well,

Treatment Approaches

Psycho-educational Theory

Psycho educational approaches are interventions that focus on providing participants with knowledge. This knowledge is presumed to assist in decreasing anxiety and maximizing coping skills (Anderson, Griffin, Holder, Rossi & Treiber, 1986). Education is conducted by way of lecture format, discussion groups, and experiential exercise. Psycho-educational groups are supportive, serving to decrease isolation and enhance problem solving (Anderson, et al., 1986). In this, members are provided with useful information regarding the relevant problem.

Cognitive Theory

Learning theorists such as Pavlov (1927), Skinner (1953) and Bandura (1977) pioneered studies on how individuals acquire and interpret knowledge. Pavlov (1927) is renowned for his contributions of classical conditioning and Skinner (1953) for his instrumental learning theory. Learning theory indicates that there is a learning correlation between a stimulus and consequence. Bandura (1977) states social learning theory incorporates the belief that individuals learn behavior through a variety of ways, such as observation, imitation and modeling. Learning theory suggests children learn behaviors through conditioning, observation, imitation or modeling. Negative behaviors are described as the negative consequence of a stimulus, occurring in the context of a trauma. Bandura (1977), a proponent of Social Learning Theory suggests behavior is learned from experience. Applying this theory to alcoholic families, the suggestion is that COAs learn alcoholic behaviors by virtue of context, observation or by experience. Heeding these principles, substance abuse in COAs is an integrated learned behavior that becomes reciprocated. Behavior comes from observing, later modeling or acting out these observations (Bandura, 1977). What delineates those COAs who model behaviors and those who don't, remains open for discussion.

Cognitive theory rests upon the premise of learning theory. Piaget (1928) introduced cognitive theory, adding an understanding of how cognitive abilities develop via an interaction with one's environment. Later, cognitive theorists such as Ellis (1976) and Beck (1979) expounded on Piaget's (1928) constructs, connecting individual thinking to patterned responses and actions. One aspect of cognitive theory describes how individuals develop the set of concepts they hold about themselves. Ingrained concepts and ideas of ourselves are predictors of how we may respond in any given

context. Ellis (1976) introduced the idea that individuals personalize and construct specific meanings to the events in their lives. Ellis (1976) suggested that people create a set of cognitions that influence their interpretation of and responses to life situations. In turn, these constructs are influenced by individual emotions.

These concepts of self are the triggers for thoughts and feelings that arise in certain situations (Bernard & Ellis, 1983). In turn, these cognitions form the path that directs individual actions and response patterns to a specific context (Bernard & Ellis, 1983). Behaviors, thoughts and feelings become interconnected in a never-ending cycle. In this manner, people can attach irrational or negative meanings to situations that become integrated into their belief system. Irrational beliefs are also known as dysfunctional thinking processes, which lead to cognitive distortions (Bernard & Ellis, 1983). Irrational cognitions result in stressful emotional reactions like depression or anxiety and intense behavioral repercussions such as anger and aggression (Bernard & Ellis, 1983). These misconceptions must be challenged and new cognitions formulated to change fixed response patterns (Bernard & Ellis, 1983).

Barth (1986) and Beck (1978) concur with Ellis (1971) that negative affect and maladaptive behavior are the result of rational belief systems. Beck (1978) offered that incorrect responses can be viewed as a set of rules. Beck (1978) suggests people internalize a set of response rules similar to Ellis' (1976) 'ABC' sequence of conversion. For example, Beck (1978) says that when an individual encounters a situation it is understood through that person's pre-established cognitive process. People develop cognitive misconceptions and beliefs that are self-signals which trigger thoughts and directing emotional reactions and behavioral responses (Beck, 1978). Accordingly, the

detrimental emotions intensify confirming the beliefs that the individual holds to be true of his/her schema or view of self. Thus, individuals become involved in a self-perpetuating process (Beck, 1978). To alter emotional reactions and change behaviors in somebody, Beck (1978) claims that misconceptions need to be corrected. COAs learn how to deal with situations by modeling those around them. These coping skills become integrated into internalized patterns of responses to given situations. One example of this occurs when children witness their parents drinking when they are feeling overwhelmed by emotion. This response cognition needs to be altered and a new option developed.

Beck (1978) and Barth (1986) contend that these changes come about when individuals become aware of their thinking and recognize that their thoughts are erroneous. In order to change maladaptive thoughts, individuals must recognize their internalized statements, (representing view of self), and by experience, challenge their hypothesis (Barth, 1986; Beck, 1978). New experiences can alter the thought processes and the subsequent response patterns.

Applied, cognitive theory suggests that acting out behaviors in children is the result of defective thinking and adverse emotional consequence. Accordingly, Beck (1978) and Ellis (1976) agree that changing the negative effect means changing the meaning attached to a person's interpretation and construct of a given context. In cognitive therapy, changes in behavior occur via two paths (Alford & Beck, 1997). One path to behavioral changes which starts by effecting changes in individual thinking patterns; this leads to restructured thinking, causing individuals to change their behavior.

Another path starts by changing ways of behaving; this leads to changes in thinking about one's view of self, and ultimately changes one's actions (Alford & Beck,

1997). Cognitive theory suggests that interventions intending to reduce or eliminate acting out behaviors are more effective when based on principles that create changes in thinking (Ryan, 1997). Cognitive theory implies that acting out behaviors are situational response patterns to pre-establish thinking triggered by emotions or events. Individuals react in inappropriate ways that become internalized patterns of response (Ryan, 1997). Clearly cognitive thought processes are evident in controlling and directing behaviors (Alford & Beck, 1997). Long-term positive outcomes are affected by contextual and relational learning (Alford & Beck, 1997).

Cognitive interventions are geared toward eliminating, reducing or restructuring entrenched thought patterns that are hurtful and self-deprecatory (Beck, 1976). Beck (1976) identifies three therapeutic processes that must occur in cognitive therapy. First, the therapist must convey that the individual's perception of reality is not the correct reality. Second, the therapist helps the individual understand that his/her interpretation of the reality is dependant on falsely integrated cognitions. Third, individuals must be able to test their hypothesis (ideas). Beck (1976) suggests that hypothesis testing depends on having reliable and sufficient knowledge about a situation to make choices. Often, people make inferences in situations based on internal cognitive processes rather than on actual information, also known as 'jumping to conclusions' (Beck, 1976).

Effective cognitive therapy occurs when the client recognizes that his/her cognitive processes are maladaptive (Beck, 1976). Ellis (1976) proposes that frequently an individual's faulty cognitions become internalized statements that arise automatically and without reflection. This implies that maladaptive "self talk" is voluntary, and changeable or switched on and off. In cognitive therapy, individuals are trained to observe the

sequence of different external events and their reaction to them and then identify their associated automatic thoughts.

Ellis (1976) describes this sequence as the 'A, B, and C'. 'A' is the activating stimulus or event, 'C', is the inappropriate, conditioned response and 'B' is the blank or bridge between 'A' and 'C' (Ellis, 1976). Therapeutically, helping individuals fill in the blank with alternative or adaptive responses to a situation becomes the cognitive intervention (Ellis, 1976). When the 'blank' is filled with adaptive responses, the individual's internalized belief system becomes challenged (Ellis, 1976). Individuals then begin to question the validity of their thoughts; new behaviors are enacted and new cognitions are created (Ellis, 1976).

How does the cognitive therapist change an individual's internalized thinking and system of rules? The major technique is to help the client be aware of his/her attitudes and decide if these attitudes are self-defeating (Beck, 1976). Once the client becomes aware of his/her distortions and the internalizing self-talk that perpetuate the distortion, the client needs help to revise his/her problem solving skills (Beck, 1976). This is accomplished by self-observation, affirming the relationship between thoughts and actions, recognizing that thoughts are hypothesis not facts, and developing awareness that the underlying beliefs generating such hypothesis are incorrect (Beck, 1976).

In addition, (Freeman & Greenwood, 1987) there are a variety of methods that effect self-examination of thought processes and behavior. Some of these include helping clients; clarify the meaning they attribute to a problem, question the evidence of their ideas, distribute the responsibility for a situation accordingly, and examine alternatives and fantasize about consequences. As well, clients can list the pros and cons

of their thinking, label their distortions, examine paradoxical situations using replacement imagery, externalize voices, and cognitive rehearsal to reinforce the new thinking (Freeman & Greenwood, 1987).

A basic assumption of cognitive therapy is that faulty thinking contributes to maladaptive behavior; changing these faulty thoughts produces future healthy behaviors and leads to improved subsequent thoughts (Cormier & Cormier, 1985). Once the client becomes aware of his/her distorted thinking, there are several techniques used to help individuals change their thinking. Techniques include cognitive modeling and thought stopping, self-instructional training, cognitive restructuring and reframing, which produce change (Cormier & Cormier, 1985).

Cognitive modeling and self-instructional training is a strategy that shows clients how and what they should say to themselves when they are performing a task. An example of this is teaching a client to give him/her self-positive instructions like telling him or herself to slow down and complete each step carefully before continuing the task. This helps the client develop self-control over his/her impulses (Cormier& Cormier, 1985). 'Thought stopping' is another technique that is taught to the client. 'Thought stopping' teaches the client to examine his/her negative self-talk and the circumstances in which it occurs. The client is taught to recognize and interrupt such comments as "I can't do this" or "I'm too stupid" by teaching him/herself to say, "Stop!" (Cormier & Cormier, 1985).

Cognitive restructuring and reframing is a strategy developed by Ellis (1976) in his rational emotive therapy. Restructuring or reframing is the process of identifying the client's irrational thoughts or perceptions, which then help the individual change his or

her irrational belief. The client is taught to discriminate between rational and irrational thoughts by reframing (Barth, 1986; Cormier & Cormier, 1985). Therapists encourage clients to compare and examine the influence that their self-defeating thoughts have on the problem versus what impact results from self enhanced thinking. The therapist models the link between emotion and events, introducing positive coping and self-statements. The client then practices his/her alternative coping and self-statements in stressful situations (Barth, 1986; Cormier& Cormier, 1985).

Cognitive reframing is a technique that encourages clients to reflect on their thinking or events from a different perspective (Barth, 1986; Cormier & Cormier, 1985). This is done by reframing or challenging the meaning a client may have attached to a particular problem behavior. In the past, that attached meaning has maintained and perpetuated the problem. Often people become fixated on this pattern of thinking and only see things only from this perspective. The assumption is that once the meaning is changed, then the behavior changes provided the new meaning is valid for the client (Cormier & Cormier, 1985).

Cohen & Schleser (1984) remind therapists that one way to measure the success of cognitive therapy with children is to observe whether the child has generalized the desired behavior to other situations. Generalized behaviors are achieved by several methods. Children are invited to use reinforcement or self-instruction which are child produced. As well, training or practicing the concepts in multiple contexts gives the child a chance to rehearse in settings that are similar to reality (Cohen & Schleser, 1984). Another technique that reinforces generalization is developing an adaptation to other situations (i.e., how to analyze similarities and differences between situations and apply

the correct techniques accordingly) (Cohen & Schleser, 1984). The link between cognitive theory and its use with COAs is clear. Cognitive theory is relevant to group interventions with COAs as an effective means by which to adapt coping skills and break the cycle of dysfunction.

Solution Focused Therapy

The solution-focused model is a contemporary approach, emerging out of the social constructionist trend of the '90's (Nichols & Schwartz, 1988). Most therapeutic models, solution focused included, developed from the presuppositions and assumptions of their respective times. For example, Freud's (1926) focus on repression represented his beliefs about it and in turn centered his intervention towards his biases. When we are influenced by interactions with the world around us, then we are predisposed to the answers and categories that emerge as a result. Here, the evolution of models is seen in the history of the assumptions of the questions of the original theorists (Peller & Walter, 1992).

Solution focused principals emphasize that historical information about the problem is unnecessary. Instead, a specific manner of interacting, speaking and thinking facilitates solutions to problems, and this process is unconnected to the problem's history (O'Hanlon and Wiener- Davis, 1989; Peller & Walter, 1992). A social constructionist approach places the emphasis on the future rather than the linear causality of the past. When dealing with child welfare families, this perspective melds effectively with the service time frame.

Solution focused theory also supports the notion that the client is the expert (Peller & Walter, 1992). This belief fosters independence, supporting the client in

developing resources and problem solving skills of their own accord. Thus, the client is in control and maintains the power to create productive change in their lives with skills that are portable to other situations (de Shazer, 1988). Facilitating these qualities then, a solution-focused intervention is respectful, inclusive and non-pathologizing. The historical logic of the solution focused approach, coupled with these qualities, provides an obvious rationale for selecting this theoretical framework in working with COAs.

Solution focused approaches with COAs involves basic problem solving steps that are universally applicable to any situation with a degree of complexity. Consequently, the capacity to encompass future orientation is infinite. Providing a pattern of healthy productive lifestyle choices make it appealing to children. Latency aged children are competitively driven by the energy and influence of each other (Erikson, 1963). Such groups facilitate creativity and the ability to assume alternative perspectives. Solution focused approaches generate snowballing energy. Together, the future orientation of this perspective "pays forward" as latency aged COAs graduate to adolescence and ultimately adulthood with a functional, flexible and universally adaptive means of making choices.

The assumptions and conceptual characteristics of a solution-focused model lend detail to the domino effect noted above. To start, the theory uses solution-oriented language to facilitate change in the desired direction. Focusing on the future, rather than on the past is part of this concept. Using language that speaks of a future that is different from the present tacitly implies a belief that there will be a time when things are different (Peller & Walter, 1992).

It follows that by alluding to change and using future oriented language; the therapist is suggesting that there are exceptions to every problem (Kral, 1988; Lipchick,

1988; O'Hanlon & Weiner-Davis, 1989). When there is hope, the problem becomes less omnipotent. Solution focused theory is staunch in its premise that there are always exceptions. Exceptions then become building blocks for solutions, as people brainstorm ideas on how to address the situation.

The idea is that change is ongoing and related directly to the assumption of exceptions. Identification of a time when the problem was not in control suggests that things have changed and will continue to change. Solution focused theory asserts that within this ongoing change, even small changes lead to larger changes (Kral, 1988; Peller & Walter, 1992). Kral (1988) notes that "a domino effect" occurs within even the briefest intervention that may effect change of any size. The thought of unity in solution focused theory adds emphasis to this idea, while the "domino effect" allows one member to change a whole family (O'Hanlon & Wiener-Davis, 1989; Peller & Walter, 1992).

The strengths of this model are clearly illustrated above. Primarily, it is quick, easy and practical in its application. Qualities such as this make it easily learned through modeling. Incorporation into daily problem solving mechanisms allows it to be very portable (de Shazer, 1988). By virtue of this feature, solution focused theory empowers clients in dealing with future problems. Reduced is the cost and repetition of service to the service providers. Finally, the solution-focused perspective can be initiated with little or no information, and the results can be quick, which are very validating to the client and social worker.

Parallel assumptions between models include the following: small changes are generative; meaning and experience are seen as interactionally constructive; change is

recursive; unity of inclusion, i.e. where change in one client affects future interactions with others involved (Bowen, 1974; Peller & Walter, 1992).

Kral (1989) has outlined successful solution focused models of intervention with latency-aged children in group settings, particularly through the school system. In teaching generalized methods of problem resolution it provides the opportunity to recapture the lost qualities of ritual and consistency within this area of functioning. Ritual and consistency become reintegrated when the formula for problem solving is applied to the contexts in which they are used.

Finally, a solution-focused model supports the client as the expert who is collaborating with the therapist (Kral, 1988; Peller & Walter, 1992). The therapist is part of the group treatment and acts as a catalyst for solution building, encouraging the brainstorming and recognition of strengths that preclude discovery of a solution (Kral, 1988; O'Hanlon & Weiner-Davis, 1989). It is these suppositions that provide basis for the solution-focused approach.

The strengths of the solution-focused methodology are also illustrative of its downfalls. For instance, the approach places little emphasis on data gathering. At the same time, this quality narrows the focus of the intervention. As a result, it would be limiting to use this approach in isolation. A complementary model such as the narrative approach widens the scope of coverage.

In all, a solution focused approach fits well for group work with latency aged children in that it encourages brainstorming, independent thinking, and it builds coping strategies within a structured setting. This then serves as a practical context for group-generated ideas to emerge. Latency aged children, in their increasing focus on

independence and peer relationships lend them selves as the ideal population for this mode of intervention (Erikson, 1963).

Narrative Therapy

Similar to solution focused therapy, narrative theory (Hastings and Typpo, 1984; Freeman & Combs, 1996) proposes the client is his or her own best resource. This outlook is imperative for building self-esteem and a sense of self-control. These traits are achieved by using creative approaches available; creativity is necessary when working with children. Examples of these qualities can be seen in the focus on the client telling his/her own story, arriving at their own conclusions, leading to solutions with meaning. Similar to solution focused theory, narrative theory understands that individuals make their own meanings or stories from situations and events. This 'meaning' directs how they will respond to other similar events. The "Challenge Model" (Wolin and Wolin, 1995) melds these concepts into a well-rounded approach. When working to promote resilience in COAs, it is important to base one's intervention upon a belief in the respect and dignity of all. A focus upon empowerment should be used, coupled with an emphasis upon the right to belong and to be heard.

Narrative therapy builds on the premise that reframing negative cognition can change unhealthy thoughts and behavior. Narrative therapy attempts to shift thinking by using tools such as story telling to offer new hope and choices. Providing the chance to change, narrative therapy acknowledges that the client is the expert in his/her situation and encourages him/her to find the new meaning to "old" stories to help them move in the desired direction of their therapeutic goals (Nylund & Smith, 1997). The client is

viewed as the most knowledgeable about his/her circumstances and as having the ability to "re-author" his/her stories (Nylund & Smith, 1997).

In narrative practice, people discover new stories about themselves based on their strengths, hopes dreams and preferences. Narrative therapy externalizes problems, permitting a forum that makes the process more controllable and less intimate (Nylund & Smith, 1997). Language is key to this model, and is used to maintain a respectful position vis a vis the client. Therapists use reframing and restructuring questions to change a client's negative thoughts to more positive ones. These tools (restructuring and reframing) are comparable to Solution focused theory (Nylund & Smith, 1997). The qualities of narrative therapy empower children to look for alternative interpretations and subsequently a wider range of solutions. Inherently, children recognize they have the control and capacity to shape their own actions and that they could take control in places they previously assumed they could not (Kral, 1989; Freeman, Epston, Lobovits, 1997). For COAs, these beliefs and understandings are crucial to creating the qualitative foundation for facilitating alternative skills, choices and realizations. With such changes, it can be anticipated that there will be less evidence of dysfunctional patterns of daily living.

Creative approaches to narrative work involve strategies like dramatization, art, sand play, role-playing or story writing. Such creative approaches are essential in working with children as they enhance communication. They allow children to combine imagination and knowledge while providing a lighter, more comfortable atmosphere (Freeman, Epston & Lobovits, 1997). The clinician assumes a collaborative, "co authoring" role with the client in therapy. Together, the therapist and client, co author the

therapeutic process. Critical in this approach, is respect for individuals, their own untapped resources and their ability to problem solve. In this process, clients are given the opportunity to examine alternative ways of thinking and behaving, choosing the ones that are most valid and meaningful for them. Children can accept responsibility, uncover a newfound self-confidence and gain insight to their own issues though narrative techniques (Epston et al., 1997), a process that offers hope and effects change. These narrative strategies facilitate children becoming increasingly aware of different perspectives on situations without passing judgment and remain respectful of the people involved.

Narrative therapy offers acting out children a means to externalize what may often seem like shameful behaviors. In addition, narrative therapy allows children to place distance between themselves and a sensitive topic. A variety of forums such as story telling, puppetry or crafts can be introduced to help educate children, increasing their awareness of cognitive distortions. At the same time, different mediums can encourage COAs to examine alternate thoughts and practice adaptive behaviors.

Narrative therapy has an additional merit in that it advocates for a child-centered approach. This model helps children find meaningful ways to solve their own problems. Narrative therapy also has parallels to cognitive theory. Narrative therapy offers children the chance to reframe faulty cognitions and change their maladaptive behaviors for positive ones through re-authoring.

To summarize, many aspects of group theory, cognitive theory, narrative and solution focused theory fit well with this population. In this, cognitive theory is relevant to group interventions with COAs as an effective means by which to adapt coping skills

and responses and to break the cycle of dysfunction. Children are facilitated in a non-judgmental way to become increasingly aware of different perspectives on situations. Latency aged children, in their increasing focus on independence and peer relationships, (Erikson, 1963; Peleg-Oren, 2002) lend themselves as the ideal population for this integrated mode of intervention. Amongst their peers, healthy coping skills, self-care and self-esteem become integrated into patterns of responses to everyday situations faced by COAs.

In light of the previously documented qualities that places COAs at higher risk, both Reinhart (1999) and Roosa, et. al., (1989) found that group interventions assist children to become more self reliant, more emotionally confident and possibly less depressed. Moreover, group interventions were found to prevent children from regressing during stressful times; it helped them cope with stress arising from parental substance abuse (Reinhart, 1999). These findings support the premise that moderating the stresses flowing from parental substance abuse may improve the mental health of the children.

Solution focused therapy and narrative therapy are both also informed by cognitive theory. This offers the most congruent complement for the therapeutic process. Narrative therapy is considered an effective means of actualizing goals of cognitive therapy. A narrative approach reframes cognitive structures that help sustain acting out behaviors. In seeking to effect changes in inappropriate behaviors in young children, cognitive theory provides an understanding of how behaviors become internalized responses for children and how to change those patterned responses (Beck, 1979; Ellis, 1971). Narrative therapy offers a compatible, child sensitive approach that helps children create and implement alternative ways of thinking and subsequently, acting.

Incorporated are different levels of play that appeal to children. This is one of the preeminent means by which to access and join forces with imagination and knowledge, simultaneously providing a playful atmosphere (Freeman, Epston & Lobovits, 1997). A group environment offers the most support for the participants and provides a chance to try out new ideas and practice their learning with peer feedback.

The intervention described in this report was based on the belief that COAs have strengths. These strengths, when built upon can make a dramatic difference in the level of resilience in COAs. Side effects of increasing strengths will be less dysfunctional habits and more positive qualities for this population. Narrative therapy parallels cognitive behavioral theory, providing a complement for the therapeutic group process. In seeking to effect changes in these areas of COAs, cognitive theory presents an understanding of how these become internalized responses for COAs and thus how to alter those patterned responses (Beck, 1976).

Individual versus Group Intervention

As compared with individual interventions, group approaches cost less money and can be more beneficial (Blane, 1988). Bergin & Riddle (1997) indicate group counseling is effective in helping COAs improve their self-concept and lower anxiety levels. This study found school aged children developed elevated, more effective social skills, strategies for coping, and learned that they were neither the cause nor the cure for alcoholism (Bergin & Riddle, 1997).

Group intervention, as opposed to individual approaches with this population, can provide an alternative unit of socialization. Socialization provides a format for the development of skills that COAs may not glean from their family of origin (Emshoff &

Price, 1997). This is especially relevant to latency-aged children, whose focus is increasingly on peers and their activities as opposed to individual pursuits. The group can come in many forms and offer multiple resources. Group counseling decreases social isolation and negative feelings, which can lead to increased peer relationships, sense of belonging, resiliency and enhanced coping skills (Arman, 2000; O'Rourke, 1990). These outcomes suggest that group work, as opposed to individual interventions may be more beneficial in the long run for this population. A group environment provides the stage for COAs to try out new ideas and practice integrating what they have learned.

Group Theory

Group work practice began in the early 1900s and was traditionally affiliated with education and community work. As it developed, group work was seen as a therapeutic intervention in the mental health setting (Rivas & Toseland, 1998). Over the years group work has developed into an independent field of study. Eventually, group work was adopted by social work as a useful intervention tool (Rivas & Toseland, 1998). Early group work contributed to several models of intervention. Rivas & Toseland (1998) identify the initial group models of the 1960's as social, remedial and reciprocal. The group purpose often defines the chosen model. Social groups focus on socializing members to social values and operate on the power of group action (Rivas & Toseland, 1998). The group format involves discussion and carrying out of tasks that effected social change. The group goals are accomplished through group activities.

Remedial groups focus on rehabilitating members through a facilitator-centered approach that uses structured tasks such as problem solving. The group focus is to change the individual's behavior through the group context (Rivas & Toseland, 1998). These

groups are frequently used in mental health settings with people exhibiting serious behavioral problems.

Reciprocal groups stress the interdependent interactions between group participants and society. This type of group assumes that their environments influence individuals. The reciprocal nature of the group involves the facilitator and participants working together to address the group issues. In a reciprocal group the emphasis is not on individual participants but on the progress of the group as a whole (Rivas & Toseland, 1998).

In later years, these three models were integrated to form a fourth category of group work. This became known as a mainstream model of group work and includes remedial, reciprocal and social group elements, as well as therapeutic components (Rivas & Toseland, 1998). This mainstream approach is based on mutual aid. The purpose of the group is defined by the common goals of the facilitators and participants (Glassman & Kates, 1990). The goals are achieved through group interactions; activities and tasks that problem solve, make decisions and deal with conflict (Glassman & Kates, 1990). The group participants develop and practice alternative ways of thinking and behaving through a supportive group process. The framework of this mainstream model was used for this practicum.

In later years, social work groups became associated with a variety of different group interventions. These include structured groups, psycho educational groups, psycho-therapy groups; self help groups and support/action groups. For the purposes of this practicum structured psycho educational/therapeutic groups are explored further.

Group members coming together around a common issue characterize psycho-therapeutic groups. This type of group attempts to provide rehabilitation and behavioral change through the use of mutual support, peer feedback and group interaction (Garvin, 1997; Rivas & Toseland, 1998). Therapy groups help members address personal issues, alter their behavior and develop coping strategies (Johnson & Johnson, 1997). Facilitators provide constructive confrontations and helpful feedback (Johnson & Johnson, 1997).

Structured, time limited groups are interventions that have predetermined curriculum and goals set by the facilitators. These types of groups are time limited in nature by the number of sessions that will evolve. The facilitators also predetermine the length of the group. Since the nature and objectives of the group are pre-selected, group members join as a source of help and service.

In the 1960s small group work entered the realm of generic group work practice (Garvin, 1997). The values of small group work included the right to mutual aid and support within the group, the right to empower its members and the right for the group to facilitate understanding for its members (Rivas & Toseland, 1998). These generic values parallel social work principles. In social work groups, workers respect and value the inherent goodness of people. Respect and dignity for the worth of others and empowerment are strategies that help group members overcome interpersonal difficulties (Glassman & Kates, 1990). Small group work theory builds on the mutual aid principle; this principle provides that participants come together, helping each other process common agendas. This system is founded on humanistic values that guide the process in which participant and facilitator will work together, interact and deal with conflict (Glassman & Kates, 1990).

Small group theory supports the values and premise of humanistic group work (Glassman & Kates, 1990). It includes humanistic values, which prevent stigmatization, acts of violence, stereotyping and blaming of others. Groups are seen as one method of intervention that maximizes empowerment for socially boycotted and oppressed people. The group operates in a democratic medium, facilitating the establishment of group norms under such a system. Groups act under the premise that people are responsible for one another; such values as respect for the inherent worth of others are strengthened. Everyone has the right to freedom of speech, the right to choose and the right to question and constructively challenge others (Glassman & Kates, 1990). Small groups facilitate change in members based on the interaction between participants and facilitator. Small group theory proposes that the group dynamics contribute to the effectiveness of the group intervention.

Group maturation is observed to occur in sequential periods throughout the life of the group (Garvin, 1997; Rivas & Toseland, 1998). Most theorists agree that all groups pass through similar phases of development, but some theorists outline other levels of group progression such as the pre-group, the planning and the pre termination stages (Rivas & Toseland, 1998). Another group development theory (Garland, Jones and Kolodny, 1965, 1972) compares the development of a group to the lifecycle: birth, growth and death. This model emphasizes the importance of how group members struggle to form closeness. Different conflicts are observed concurrently at each new stage of group development. These conflicts are pre-affiliation, power and control, intimacy, differentiation and separation (Garland et al., 1965; 1972).

Generally, every group is observed to follow three chronological steps as group formation takes place (Garvin, 1997; Rivas & Toseland, 1998). These steps are characterized according to the organization of participant interaction as it impacts on group maturation and cohesion (Rivas & Toseland, 1998). Each group is viewed as encompassing the beginning, middle and end stage of group. Each stage is characterized by discernable structural differences (Rivas & Toseland, 1998). A description of the principle differences follows.

The conception or idea for the group characterizes the beginning stage of group work. This phase focuses on the preplanning and organization of the group, establishing the location, the purpose, the goals, the tasks, the membership, and the recruitment. As well, the beginning point of the group centers on the orientation of participants to group. In this stage members are in the pre-affiliation stage; their connection to the group is dependent on common life experiences (Garland et al., 1965; 1972). During this time, group members characteristically display ambivalence and approach-avoidance tactics as they resist becoming a part of the group. The development of trust among members is crucial to further group growth (Garland et al., 1965; 1972). Garvin (1997) emphasizes that conflicts may occur among group participants as roles, norms and processes are established. Facilitators normalize the process and facilitate problem solving among group membership (Rivas & Toseland, 1998). At this phase, the group dynamics center on establishing the purpose, values, roles and norms of the group interaction (Garvin, 1997; Rivas & Toseland, 1998). At each new level of group development different dynamics occur, reflecting the growth of the group.

As the group norms and roles become established, the group enters the middle stage of development. This phase is classified as the working level of group development where group structures of power are formed and intimacy develops (Garvin, 1997; Rivas & Toseland, 1998). The group achieves cohesion after group members have established group norms, roles and patterns of interactions. Together the membership begins the process of accomplishing the tasks and goals that were decided upon. Several terms such as problem solving, intimacy, maintenance, power and control, stage and performance are used to describe this level of group maturation (Garvin, 1997; Rivas & Toseland, 1998).

The final stage, the ending or termination of group, is characterized by the completion of group tasks or goals. This phase of group development is accompanied by evaluation and feedback of the group process. Review and the celebration of the group achievements (Rivas & Toseland, 1998) mark the final step. The dynamics reflected at this stage may return to the approach-avoidance behaviors observed in the beginning interactions. Members may feel angry that the group is over, be ambivalent, or show signs of flight/withdrawal (Garvin, 1997). The group feeling of cohesion begins to deteriorate and the facilitators support the process of the group separation, returning to a focus on the individual (Rivas & Toseland, 1998).

Group dynamics are characteristically different at each level of group development. Dynamics are the communication and interaction patterns observed between group members (Rivas & Toseland, 1998). Dynamics demonstrate group cohesion, subgroups, power and status and the social control that maintain interactions within a group (Dimock, 1976; Garvin, 1997; Rivas & Toseland, 1998). Group dynamics can contribute or detract from the achievement of a group's goals and tasks (Rivas &

Toseland, 1998). As the group evolves, it develops its own culture. This culture is a mixture of the values and beliefs of the group members and the influence of the environment. Together, the group membership forms its own culture from the varied backgrounds. The group culture affects the functioning of the group dynamics, it decides how and what tasks are addressed (Rivas & Toseland, 1998).

Group facilitators should have knowledge of the many stages of group development and dynamics so that they can intervene when it appears necessary to facilitate the group process (Rivas & Toseland, 1998). An understanding of group stages provides the facilitator with the knowledge that can be used to promote positive group dynamics (Berman-Rossi, 1992). Knowledge and understanding regarding the stages of group development and group dynamics help group facilitators determine several points of intervention (Dimock, 1976; Garvin, 1997; Rivas & Toseland, 1998). Pre-knowledge helps the facilitator predict events, see where in the group process their intervention is necessary and to help the members move through the stages. This understanding provides the group facilitators with the ability to assess how the group is processing, checking that members are supporting each other and addressing the tasks at hand. Group facilitators need to assess several areas of group growth, such as roles, norms, tasks, and rules; they must also assess communication, belonging, and the development of trust (Rivas & Toseland, 1998). Group development models help the group facilitator maximize the potential of the group, assess if it is developing as expected and when and how to intervene if it is not (Rivas & Toseland, 1998).

Alternative in the Literatures

There have been several previous attempts to address children of addicts over the years (Roosa, et. al, 1989; Reinhart, 1999; Peleg-Oren, 2002). Reinhart (1999) evaluated a 6-month long group intervention for COAs, designed to assist COAs in coping with stress and disruption associated with parental alcoholism. The group was geared specifically to children whose caregivers/parents were in treatment. The treatment approach was based on a psycho educational perspective integrating a variety of theories. These included; solution focused, social cognitive and cognitive behavioral theories. For example, the use of games with therapeutic themes, analogies and role-playing were used to educate and to reinforce change responses to scenarios faced by COAs.

The goal of Reinhart's (1999) intervention was to discover what, if any, changes group interventions initiated. Reinhart found that the most pronounced change related to the area of self-reliance; this result alludes to the possibility that group intervention may increase personal adjustment and capacity to cope with stresses. The group intervention format was seen to be proactive in inhibiting regression during personal and familial change. Reinhart (1999) concluded that his findings constituted a further replication of the findings of previous studies by Roosa et al., 1989.

In reference to the above note, Roosa, et al., (1989) carried out a similar group process. The notable difference between Reinhart's (1999) model and Roosa's model was that the target population of Roosa's study resided in families in which there was no likelihood of change as the caregivers were not in any treatment programs. The purpose of the evaluation was to assess the feasibility and likelihood of success of a school based prevention program for elementary school COAs. The program focused on teaching

more effective ways to cope with stress, operating on the assumption that stress would not decrease for the COAs. Results indicated that COAs under the age of twelve could be taught to use positive coping strategies, building in this way a foundation for a successful preventative intervention (Roosa et al., 1989). This study deals with the same target population, both in chronological age and in context, as the practicum aimed to serve.

Peleg-Oren (2002) offered a specific group intervention model for COAs, as part of a rehabilitation process involving the whole family. Peleg-Oren's model evaluated a group intervention for COAs aged 8-11, run over an 18-month period. The theoretical approach utilized is referred to as "Activity Interview Group Psychotherapy". The goal of this intervention was for the improvement of COAs self confidence with an ultimate aim to reduce the risk of the COAs repeating their parents' addictive behaviors by decreasing the sense of isolation, increasing social cohesiveness and emotional awareness while offering a stable and predictable routine. Qualitative evaluative tools were primarily used in the evaluation process. The evaluation included a review of documentation of sessions, individual discussion with the children, as well as group feedback assessed effectiveness. Factors drawn from the reviews were then pooled to analyze the process and its effect on the child. The group was deemed to be at least moderately successful.

Historically, the interventions found in the literature purport to be at least minimally successful in helping COAs gain a higher level of functioning than they otherwise would have. Prior to these groups, interventions carried with COAs were usually done at schools and were poorly documented. It was not until treatment facilities began to offer interventions for COAs that records on the process and outcomes start to

appear in the literature. Documentation existed for models designed for COAs whose parent's were either currently in treatment, or who had been in treatment; COAs were identified related to their parent's treatment status. Few models focused on the preteen target population specifically, with the majority attending to teen-aged COAs.

The literature review indicates support for a child focused group intervention with COAs. The suggestion was that this approach may be the most useful means of affecting an increase in the moderating variables required to induce resilience in COAs. Supporting this population within their family/caregiver environment aims to increase their level of functioning while assisting in the successful negotiation of childhood. The intrusive and often ineffective child welfare interventions of the past could be avoided in part by teaching coping skills and resourcefulness to COAs. This could lead to COAs becoming healthier adults thus creating a healthier next generation.

Hastings and Typo (1984) pointed out that the target population of children between the ages of eight and eleven require further consideration with respect to group process. Hastings and Typpo (1984) placed emphasis on the connection between physical growth, cognitive changes and social development and how these factors affect the way children perceive and interact with the world around them. The unique dynamics of an alcoholic family's impact on the child's perceptions of self and behaviors make for confusing messages to children (Hastings & Typo, 1984). Group treatment design requires that these factors be carefully considered if the goal of providing ritual creation, protection and resiliency are to be achieved (Hastings & Typo, 1984). A psycho-educational approach easily incorporates such factors and adapts these requirements to

any range of cognitive abilities, as noted by Hastings & Typo (1984); Blane (1988); O'Rourke, (1990) and Emshoff & Price, (1997).

Logically, design methods for group work with children must integrate themes and knowledge of the interaction between developmental stages and family dynamics (Hastings & Typpo, 1984). It is imperative for participants to find a level of success in the completion of the process. Erikson (1963) described the latency stage of development (8-11 years) as involving the social condition ideal for providing training and encouragement, leading to the psychosocial outcome of "industry". A successful transition through this stage yields a sense of pride and/or positive self-regard. When this process is compromised (i.e. by alcoholism) and the social conditions are inadequately met, the outcome is "inferiority, or the sense of shame and doubt about abilities and self perspective" (Erikson, 1963). Latency aged children are appropriate for a group intervention because peers become increasingly important during this phase and are significant in the process of achieving milestones (Peleg-Oren, 2002). As noted, an Eriksonian (1963) perspective views 8-11 year olds as a stage during which children develop feelings of increased independence and their activity levels often support a group model of intervention.

This writer proposes that a child with some sense of their own value and a strong locus of control will tend to assert and advocate for him/herself within that world. It has been this writer's experience that the COAs who "weather the storm" most effectively are those who have the skills and knowledge that allows them to seek out supports elsewhere. They are able to advocate, to some extent, for the opportunity to develop their strengths while accessing the guidance they need to do so. Concurrently, it is appealing to the

client's belief systems in that the focus is on the future rather than on the unalterable past. A multi-focused group model emphasizes the future and solutions, making it a clear choice for intervening with mandated families.

DESIGN OF INTERVENTION

The literature review directed the integration of several perspectives into defining the proposal of group work involving latency aged COAs. The review suggested a child centered psycho educational group approach focusing on COAs vulnerabilities such as poor coping skills, self-blaming, and anger management. In turn, program goals would ideally address the building of coping skills to areas of vulnerability. O'Rourke (1990) and Blane (1988) recommended that child centered psycho educational groups be time limited and have a closed membership, be between 8-12 sessions in duration, and limited to no more than eight participants. The sessions should focus on several key points; 1) exploration of feelings, 2) building self-esteem, 3) coping skills, 4) stress management, 5) decision making and 6) primary relationships. These choices were made because children benefit most when assisted to comprehend addiction at affective, behavioral and cognitive levels (Blane, 1988; O'Rourke, 1990; Price & Emshoff, 1997).

The review suggested that reinstating the predictability and power of a nonalcoholic routine within COAs families can contribute to COAs learning how to better negotiate their childhood. To do this, the COAs need to be enabled and supported to become resourceful, efficient and creative in accessing what they need, either lowering exposure to alcoholism and the problems associated with it, or increasing protective factors (Werner, 1986). Emphasizing strengths and teaching children how to best utilize them within a home where substance abuse is a harsh reality is one way to enable and support them.

The challenge for the professional is to decide where to focus the interventions. AFM (2000) suggested that helpers in the various agencies become more sensitive to the

children and their needs. AFM (1994) purported that an early intervention program is required to lower the chances of COAs repeating the pattern of their caregivers. A further review of the literature on COAs assisted in clarifying COAs experiences, strengths and weaknesses. Consequently, the clarification of target goals and the most effective intervention to facilitate these goals were identified.

Of interest was lowered long-term risk (as compared to risk related to not intervening) to COAs by shifting the focus of intervention to the children, specifically preteens, aged 8-11 years. Roosa, et al., (1989) found that when the focus was on children under the age of twelve, vs. over twelve, fewer symptoms were exhibited (i.e. acting out behaviors). Roosa et. al., (1989) suggested spotlighting prevention, supporting this younger population as the focal point. Additionally, this target population seems to be under represented in services within the city of Winnipeg. Available to adolescents are a number of therapeutic interventions, including Alateen and other community based one on one resources such as individual counseling services and play therapy accessible through general individual counseling. COAs up to about age seven or eight years old might access Alatots however, in the city of Winnipeg, this resource does not exist. In contrast this age group is not developmentally advanced enough to integrate and benefit from group supports designed for teens. Clearly, there is a gap in services for a vulnerable group of young people.

Objectives

The practicum methodology was intended to bridge this service gap by providing a group intervention for latency aged COAs. The group purpose was to assist COAs to

understand their family dynamics and develop ways to cope with their difficulties outside the family unit. In this context the desired objectives were as listed below.

1) To develop an understanding that substance abuse is a disease.
2) To facilitate an acceptance of limitations in controlling the addict's behavior.
3) To learn alternative and healthy ways to cope for themselves.
4) To foster and practice alternatives (i.e.; problem solving skills).
5) To decrease their sense of hopelessness (i.e.; self esteem, locus of control, etc.).
6) To develop awareness of feelings.

Finally, practicum objectives related to this writer's learning included broadening clinical social work skills in a therapeutic milieu as well as developing a means of reflecting on program impact, data collection, analysis and evaluation (Canino & Spurlock, 1994; Sayger, 1996; Austin & Prendergast, 1991).

A planned psycho educational element was delineated, and consisted of education relative to alcoholism as a disease, resulting family dynamics, and how to manage as a member of the family unit (Pilat & Jones, 1987). A cognitive approach developed a base for therapeutic reframing, restructuring and examining alternative reaction and coping skills. Cognitive theory contributed to skills training for handling social situations, problem solving techniques and healthy coping techniques (Alford & Beck, 1997; Beck, 1976; Cormier & Cormier, 1985). A narrative approach endorsed the cognitive reframe (Epston et al., 1997; Nylund & Smith, 1997). Utilizing the narrative model allowed COAs an opportunity to tell their story in ways meaningful to the individuals and to then "re-author" that story in ways that were more positive.

A range of group activities was utilized in an effort to reinforce the principles presented. Some of these activities included watching and discussing videos, story telling, brainstorming/list making, dramatic presentations, making crafts and playing games. Ongoing assessment of the age, materials and group members' needs were completed with the assistance of evaluations, weekly journaling (participants) and informal feedback from the membership at the end of the sessions.

Rivas & Toseland (1998) stated that groups can be typically divided into many classifications. Over time, social work groups have become associated with any number of group interventions. These have included structured groups, psycho educational groups, psychotherapeutic groups, self-help groups as well as support and/or action groups. The structured psycho educational/therapeutic groups were explored for the purposes of this practicum.

Group Design

Several factors were considered when designing a group for latency aged children. Respect for the identified problem of this population encouraged a structured, closed group format. Children living with alcoholism in their families cope with situations that cause shame. COAs often take great pains to cover up for the problem in an effort to maintain a family. Alcoholism can be painfully embarrassing for the children to discuss. More frequently COAs remain in a perpetual state of crisis because of the unpredictable and erratic boundaries within their home.

A structured group was chosen because it was necessary to establish and model clear boundaries and predictable membership for these children. A stable structure was chosen to provide predictability, creating an environment of safety and trust (Hastings &

Typpo, 1984). Anderson (1980) pointed out that the use of structured group experiences can also be useful in several ways. Structured activities such as a list of group norms can increase the participants' awareness of the group process. Group members' autonomy and interdependence may be maximized by structured activities in the group. Participants can assume responsibility for what the group needs to do and each member may assimilate what makes sense for them. Additionally, structure provides the group and its members a way to evaluate the usefulness of the experiences introduced. In this, each participant has the opportunity to choose what is useful to his/her individual growth (Anderson, 1980).

The chosen group format was a psycho educational treatment group that incorporated humanistic values in addition to a mutual aid component (Glassman & Kates, 1990). The group intervention followed an outline of sequential, overlapping themes. These included themes of families, change, feelings, coping and safety planning as this pertains to addictions. The content was designed to become more challenging as the group progressed through topics, based on readiness and degree of comfort of the participants (Corey & Corey, 1992).

The methodological approach used in the group emphasized a structured, closed setting, which supported resilience building and prevented unpredictable change. Hastings and Typpo (1984) suggested the psycho educational approach. Hastings & Typpo (1984) reinforced using group sessions that have a sequential and predictable structure. At the same time, they suggested that content needed to be flexible, depending on the cognitive level of the group. Structured, time limited groups were interventions that had predetermined curriculum and goals set by the facilitators. These types of groups were limited by the number of sessions allowed and to when new members could join.

For example, beyond the second session, no new members would be added to the group. Since the objectives of the group were pre-selected, group members joined the group as a source of help and service.

None of the interventions reviewed evaluated the exact intervention being proposed by this writer. The theoretical approach identified by Roosa et. al., (1989) was the Stress Process Model, a curriculum which focused on stress management. This was effected in the following practicum by incorporating solution focused, behavioral and rationale-emotive approaches, allowing a flexible and open content, which could then be adapted according to the group's needs.

Group setting.

A 'child friendly' approach that encouraged a location outside the structure of a mandated Child and Family Services agency was preferred. Failure to create a sensitive environment may have compromised participants' feelings of safety, affecting attendance, and perhaps increasing fears and anxieties. Child protection services may have been involved with a family because of abuse or neglect related to the addiction. Children may be reluctant to attend a meeting at the same setting, which may revive difficult memories and feelings of fear or apprehension. Consistency was best served by using the same space for the duration of the group (Mandell, et al., 1989).

The 'child friendly' setting was located at Marymound, Inc., and included a large room used for the meetings, containing several chairs, and a table. A portion of the room had a couch and other required equipment such as a flip chart, television and video recorder. The room had a kitchenette with a microwave and a bathroom. The room was decorated with a number of colorful items, designed to gain the attention of the members

for the purposes of dialogue and relevance. The main table was covered with a large sheet of paper and secured to the underlay. Placed in the center of the table was a selection of coloring utensils including markers. The purpose of this was to provide the children with an area to "doodle" during the course of the sessions, should they so wish, without disrupting the group process. Additionally, the "doodles" left on the paper lent insight for reviewing the group process, specifically, lending some understanding to the memberships' tacit thoughts. The size and layout of the room reflected a comfortable working environment.

The selection of midweek days ensured the sequential, weekly nature of the group avoiding cancellations due to long weekends. Two groups were run concurrently, one on Tuesday and the second on Thursday, in order to meet the required time commitment for MSW candidates and scheduling school aged children. A snack was provided at the start and again at the half way mark of the sessions. In addition, the group ran for eight weeks. Fall months were chosen to reduce the sense of confinement that warmer weather brings. The proposed composition of the groups was eight participants of either sex between the ages of 8-11. Careful selection of participants was required to establish an appropriate balance of dynamics within the group (Corey and Corey, 1992). The selection process involved prescreening interviews and considered factors such as; readiness for group work, ability to engage and to process information. The purpose of preliminary interviews was to establish candidates who did not meet the original criteria. These interviews assessed the children's social skills and comfort with entering a group setting, as well as determined the degree of parental/caregiver support and involvement. A second, private interview with the parent/caregivers/legal guardian provided the

opportunity to obtain a clear portrayal of the comfort level, some history of the child's predominant issues and behaviors and a social history (Appendix D). An effort was made to focus on collecting information during the planning and preparation for the group as well as in preparation for the management of group dynamics, identifying potential areas of difficulty for group work. Most importantly, the described process facilitated a better choice of membership dynamics that balanced the age range. Factors that would make a child an inappropriate referral for group membership would include unwillingness to be in a group setting, severe mental health issues undermining logical and coherent thought processes or extreme behaviors placing the child and those around him/her at risk of physical injury.

Recruitment.

In a specific treatment group, the criterion for membership selection outlined common problem areas (Rivas & Toseland, 1998). Group participants were required to meet the following classifications (a) aged 8-11 (b) had a caregiver or significant other identified as an alcoholic and (c) were in a stable environment. The request for referrals was advertised throughout Marymound, Inc., Winnipeg Child and Family Services, Provincial Regional Agencies, First Nations Child Welfare Agencies and privately funded organizations. A request for referrals, listing the group criteria and describing objectives was attached to the referral form (Appendix A & B). Referral requests were sent prior to the commencement date of the group, allowing a time period for response. Selected referrals were scheduled for pre selection interviews (Mandell et al., 1989; Toseland & Rivas, 1998).

Group structure.

Corey and Corey (1992) offered a practical guide for developing group work as an intervention, instilling resiliency among individuals in the group. The emphasis on the preparatory phase, written proposal and membership covered the basic foundation of group formation. Screening and selecting of members outlined rationale for multiple perspectives and consideration of group participants. The foundation of a productive group intervention is built on careful considerations. These principles addressed group composition, size, frequency, length, and place; voluntary vs. involuntary status and open vs. closed groups. Other factors were clear ground rules and expectations for facilitators and members to increase odds of a successful intervention. Corey and Corey (1992) ended with a review of research supporting the integration of cognitive and behavioral approaches and the integration of evaluation methods into the group process as a final suggestion.

To summarize, many groups evolve through a predictable sequence of stages, with progression of dynamics and interactions between members progressing at a parallel rate. This information is comprehensive and could be generalized to the beginning phase of any group work. Corey and Corey (1992) pointed out important basic insights such as open mindedness on the part of participants and facilitators as inherent in the success of group process.

Highlighted was the significance of preserving the therapeutic value of the group process. Careful monitoring of the concepts used was required. Working with COAs in a group setting posed many benefits. For example, the setting preserved the integrity of the

group process and increased opportunity for a successful intervention. These were excellent guidelines for use with any population. Guidelines that were followed when developing a pre adolescent children's group included the following:

1. **Age**. Participants find commonalties when they were closer in age. It was helpful to assess development, social skills, and chronological age of potential members (Mandell, et al., 1989). Selection considered a combination of all these factors, seeking those candidates who exhibited a developmental, social and chronological age of between 8-11 years. Again, consideration was given to group dynamics as a preventative effort to minimize any counterproductive issues related to age disparity.

2. **Number of Participants**. Anticipated behavior problems dictated the maximum number of children a group facilitator and membership could manage (Mandell et. al., 1989). It has been both Hasting's & Typpo's (1984) experience that children coping with substance abusing caregivers, and possible secondary victimization issues, are difficult to manage. It is likely that potentially disruptive behaviors may be demonstrated in such a group. In this type of group the topics presented challenge the children to examine many difficult issues and unless there is adequate preparation, facilitators may see an increase in anxiety, which will lead to further disruptive behavior (Hastings & Typpo, 1984). The recommended maximum group membership was a staff/member ratio of one: four (Mandell et al., 1989). The maximum number of participants was eight members and the ratio of 4:1 was maintained.

3. **Time**. The time frame of the group was established according to the age of the children, their ability to concentrate, transportation arrangements and even weather (Rivas & Toseland, 1998). A selection of late afternoon or evenings lost less time to school programs.
   Missed sessions were followed up with participants, in the form of a phone call or visit to ensure that the member planned to return. Any missed material was reviewed with the member.. If a participant completely withdrew, effort was made to have closure with that individual. Closure was an important group dynamic for both group members and the facilitators.
   Most latency-aged children have the ability to sit and concentrate for an extended period of time. The minimum length of time to complete a session was 45 minutes. For older children, the maximum length is 1-½ hours (Mandell et al., 1989). Adherence to start times, end times and snack times modeled critical concepts such as boundaries, limits and structure (Mandell, et. al., 1989).

4. **Open/Closed Group.** A closed, structured, time limited group format was advocated when working with pre adolescents in a treatment group of a sensitive nature (Mandell, et al., 1989; Rivas & Toseland, 1998). Time limited, closed groups provided consistency and the opportunity to form trusting relationships. Structure helps children maintain focus and enter into the treatment process in the group work. By contrast, members in open groups may experience a constant readjustment when new members were added. This may interrupt the stage at which members are engaged. Participants in a closed group start and end the group process at the same time. It was optimal that participants were at the same stage of readiness for change or group process.

5. **Group Length.** Children and their caregivers were more prepared to commit to a fewer number of group sessions. Often, clients did not have consistency in their personal lives. Committing to a lengthy period of time would have been overwhelming. Brief lengths of time were seen as easier to accommodate. Subsequently, the choice of an 8-week long, single session a week appeared reasonable and appropriate.

In light of such suggestions, this group intervention was designed to have the least interference with school hours, therefore a 4:30 - 6:00PM time slot was chosen. Snacks were offered at the start of the group sessions, during the first ten minutes, and again in the middle of the session. For example, such snacks as a giant cookie snacks were decorated with the theme of a particular session. The proposed intervention was a closed, time-limited group because of the sensitive, emotional nature of the group content. Cohesive relationships between members encouraged the group's ability to address and resolve conflict and difficult material.

Group goals.

Group goals were defined in many ways. Group facilitators defined the group goals, or the participants delineated the goals. Goals were reassessed and reevaluated throughout the group process. In treatment groups, goals are frequently decided for the designated purpose of the group intervention (Glassman & Kates, 1990; Rivas & Toseland, 1998). This means the goals are the hopeful outcomes of the group intervention

guiding the learning process. Also, the goals characterize the common needs of the collective (Rivas & Toseland, 1998).

Common problems, interests, and needs point out the ability of the group to support and help each other, emphasizing the mutual aid system (Glassman & Kates, 1990). Glassman and Kates, (1990) stated that the process of refining and stating group goals be done in conjunction with the membership. Identifying goals directs the actualization of the group intervention. For the group that was assessed, problem commonalties defined the goals. The goals were developed to increase mediating variables such as resilience and increase self-esteem. Goals were reevaluated during the group process. The children's group goals were defined as; (a) increased understanding of substance abuse as a disease; (b) increased understanding of the common dynamics of alcoholic families; (c) decreased problematic behaviors in participants; (d) increased ability to recognize their own normal, healthy needs as children in an alcoholic family, (e) strengthened ability to cope in healthy ways, (f) increased ability to identify with peers, (g) to facilitate the development of a support network outside of family.

Group format.

The outline of weekly sessions was designed to operate for a consecutive eight-week period. Each session lasted for one hour and fifteen minutes, excluding the fifteen minute break. Snack and debriefing time was allocated for fifteen minutes during the session, completing a total of 1 and one ½ hours of group time. Each module followed a consistent structured format that permitted the integration of the specific goals and objectives. Every step of the sessions was geared to provide an opportunity to reinforce or practice one or more objectives. Each session had a beginning, middle and ending

component, modeled after group developmental stages (Rivas & Toseland, 1998). The outline for each session could be adapted to suit a variety of purposes, ages and time frames.

Every group meeting involved hands on participation activities for the members. This type of activity helped the children better absorb the program material (Mandell, et. al., 1989). The activities provided opportunity to practice the skills being demonstrated. The exercises also helped the children remain focused and involved in their learning. Active learning created interaction amongst members and facilitators, encouraging a pattern of reciprocity to develop where the children and facilitator(s) engaged in reciprocal communication developing from the games (Cormier & Cormier, 1985; Dimock, 1976; Mandell et. al., 1989). Undoubtedly, diversions were far more "fun" than sitting for lectures or discussions.

"Housekeeping" was a scheduled time for informing participants of upcoming events, programming changes or reminders. Check-ins and checkouts accorded members an occasion to discharge emotional energy, center thinking prior to entering the group process, and for debriefing prior to leaving the group (Rivas & Toseland, 1998). These few minutes offered a time to model interaction and show group support for each other. Check-ins and outs helped establish necessary boundaries, by serving as indicators for the beginnings and endings of group process (Mandell, et. al., 1989).

Journal writing was to be included for those children who had difficulty expressing themselves in the group discussion forum, allowing them to ask questions or communicate their ideas and concerns. Children had a choice of writing, dictating, printing or drawing in their journals. They could choose to have facilitators respond to

their journal entries. The facilitator(s) were to write weekly responses in the journals, focusing on the children's thinking on upcoming material or behaviors. Journals were to be helpful in exploring whether participants understood the presented theme (Mandell, et. al., 1989). Diarizing would actualize the use of narrative therapy (Nylund & Smith, 1997). Logging was to provide a place for children to record their own stories, thoughts and hopes for the future and make meaning of their situation.

Children socialized and completed scales during the last 15 minutes of the group session. This included the opportunity for the children to play free choice games or talk. This time period gave the children a chance to make friends, and facilitate the integration of the group objectives and encourage interaction (Mandell, et. al., 1989).

Between group sessions, the children were to receive in the mail material pertaining to the content covered in group, or introducing the topics of future sessions. This was intended to bridge the gap in time between groups and provide continuity of the group experience beyond the group sessions. Two weeks following the completion of the eight sessions, follow up interviews were completed.

Generally, the format was to be as follows:

1. Check-in. Approximately 5 minutes.
2. Housekeeping. Approximately 5 minutes.
3. Introduction of the main theme. Approximately 10 minutes.
4. Activities that promoted an active, integrative learning environment for each session theme. These activities were chosen for their contribution to group dynamics, group development and group interactions. Approximately 20-30 minutes.
5. Journal activity. Approximately 10 minutes.
6. Check-out. Approximately 10 minutes.
7. Completion of evaluation measures, snack and socialization time. Approximately 15 minutes.

Outline of Group Modules

The following is a proposed outline that details each group session, the objectives, and the activities used to integrate the group material. It is to be understood that sessions could and would be adapted for any number of reasons. For example, developmentally delayed children may require shorter meeting times to accommodate their shorter attention spans. Activities could be changed to reflect the ability, age, gender or culture of the participants. Throughout the process of constructing the session's structure, there was awareness that the process dynamics of any group can overturn the best-laid plans. Facilitators must be prepared to modify structure in favor of productive process, such as attending to a group member in crisis.

Session One: Getting to Know Each Other

The first stage of group work would be to concentrate on establishing trust, developing relationships, and preparing the framework for which the group norms emerge. The facilitators will create a safe context in which children can share painful experiences and feelings connected to substance abuse in their families and their behavioral responses to it. The first theme will focus on developing relationships between members and the facilitators in an atmosphere conducive to trust, mutual cooperation, acceptance and approval (Dimock, 1976: Garvin, 1997; Rivas & Toseland, 1998). At this first level, the group members and facilitators will begin to get to know each other, identifying the commonalties that lead to building trusting relationships. Facilitators will take the opportunity in this first group session to assess individual participants' level of social skills. The purpose is to help guide the intervention,

highlighting those areas that may be too sophisticated, or conversely, too basic for the children's developmental levels (Mandell, et. al., 1989).

Objectives.

Firstly, the group will define acceptable group behavior and guidelines for monitoring behavior, and about keeping confidences. Secondly, children and facilitators will get to know one another and feel more comfortable with each other. A third objective will be that facilitators acknowledge, validate and clarify common experiences among participants. Fourthly, children will realize that they are not alone, that other children live in families with substance abuse. Lastly, children will learn the effect substances have on the body and mind. Further to this last objective, children will also begin to learn that substance abuse is a disease and that they are not to blame for their family member's substance abuse.

Introductions.

Facilitators will introduce themselves, explain check-in and model the expected check-in behavior for the group members. The facilitators will openly identify and model some of the expected group behavior such as limits and boundaries and emphasize that group sessions need to start on time and end on time. A part of the expectation will be that members include a statement about how they felt being at group at each check-in. Facilitators will ask the group members to introduce themselves, by first name only and complete the check-in, by way of taking turns speaking (Duffy, 1994).

Housekeeping.

Group guidelines for the participants that help create behavior/expectations will be noted. The facilitators will address the expected behavior regarding privacy and

confidentiality in the group and ask members for input. The facilitators will also introduce the purpose for the group. A simple statement will be made about the commonalty of the participants with respect to having family members who abuse substances. The guidelines will be written on a poster board and displayed in a visible area. This will allow for a quick review of group guidelines once they were established and at any point of the group process that they needed to be revisited.

Children will be invited to share their understanding of what addictions are and where they come from. Members will be asked to brainstorm about different names for substances. Hopefully, the children will be able to describe what effect these substances have on addicted people's bodies and feelings, as well as their own feelings when they are observing intoxicated people. These items will be listed on a flip chart. Similar brainstorming is planned for shared ideas as to what an addict looks like and what makes them believe someone is an addict.

Selected activities will be aimed at facilitating the process of getting to know each other. A simple non-threatening activity intended to be fun and have the children interact cooperatively will be introduced. Anticipating that the children may operate from an individual base initially, members will be encouraged to rely on and help each other. In order to move the group from an individual focus to a group focus, the activity will have to involve materials that need to be shared.

Activity one.

Children will sit in a circle to play the game "Hot Potato". In this game the children and facilitators pass an object from person to person, until the facilitators indicate to stop. The participant left with the potato is to provide his/her name to the

group and tell one thing about themselves. That person then begins passing the potato again and designating when to stop. This activity will be played until everyone has a chance to participate.

Activity two.

The children are provided with materials with which to make collages of people they identify as possibly being addicts. The materials will include magazines and drawings of what they think an addict looks like. Each child is to be given an opportunity to share with the group why they selected the pictures on their poster.

Check-out.

Checkout will begin with the facilitator(s) to model expectations to members. Following this each member will take a turn on commenting on the group.

Journal writing.

The children will write in their journals about how they experienced the session. Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. Facilitators debrief, record the progress notes, and tidy the room after the children leave.

Session Two: Addictions as a Disease

Objectives.

In the second session, group objectives will include helping children learn that everyone has both comfortable and uncomfortable feelings and there are ways to accept and share these feelings. An understanding on how they handle their own feelings in either constructive or destructive ways will be explored. As well, the children will

become familiar with and understand the defenses they use in response to living with addicted caregivers.

Check-in.

Children will share experiences or thoughts about the previous session.

Housekeeping.

It is anticipated that it would be helpful to remind children to respect the privacy and confidences of others. Children will be asked to relay their understanding of what it feels like to be in a family when someone is addicted. What does it feel like to talk about these experiences? Who can they tell about the experiences? The concept that other types of traumatic experiences bring forth powerful feelings of fear, guilt sadness and anger will be introduced by the facilitators. The notion that feelings can come in 'clumps' and that substances can be used to hide or layer feelings (e.g., like a clown paints on a smile) will be shared. This last topic can serve as an introduction to a discussion on masks and how people use expressions to hide their feelings. The children will be encouraged to examine which feelings they feel safe to share with others. Facilitators will invite comments on what would happen if hidden feelings were expressed. Lists will be generated of healthy and unhealthy ways people cope with feelings.

Activity one.

The group will make 'feeling masks' on paper plates. The group members will draw a representation of the feelings they regularly show to others. On the other side of the plate they are to illustrate feelings they keep hidden inside. Afterward, each member will be asked to describe a time she/he felt a need to hide her/his feelings.

Activity two.

The children are given a pile of the letter C's, and asked to select three each. After a brief discussion about children's role in someone's addiction and that they cannot cause, control or cure someone else's addiction, the children will be instructed to decorate their three "C's" with a variety of craft items. The letters will be pasted collectively onto a larger poster.

Check-out.

The participants share their feelings about the group session.

Journal writing.

A suggested journal entry topic of "*What are some feelings you have had related to substance abuse in your family and how do you mask them?" will be presented.* Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. After the children leave, the facilitators debrief, record the progress notes, and tidy the room.

Session Three: Families and Addictions

Objectives.

1) To help children develop an awareness of how they feel about their families and to become aware that others are in similar circumstances. 2) To facilitate an understanding that families and family members are alike in some ways and different in others. This objective will be made tangible by allowing the children to practice expressing their feelings and offering feedback to others.

Check-in.

Facilitators invite the children to share thoughts on the previous session.

Housekeeping.

Children and facilitators will be encouraged to discuss any concerns that have arisen to date about the group. Planned for this session is discussion about the composition of various kinds of families (i.e., blended, nuclear). Emphasis is to be placed on there being many different configurations to the term of family. In addition, problems in families also come in many different forms, including family members being addicted to substances. It is hoped that this leads into a discussion about family rules. Members will be asked to generate a list of different rules in their families. They will be encouraged to identify rules that are good and bad, spoken and unspoken, and the meanings behind the rules. This topic will be a segue into siblings who are addicted and how this affects children and others.

Activity one.

A game will be used to assist children in understanding what happens to everyone in a family with substance abuse. The game involves members imagining that there is a huge blob of chewed bubble gum in the center of the floor. Volunteers will be sought to role-play an addicted person, their partner and several other family members. The facilitator will orchestrate a scenario in which everyone in the family gets stuck in the addiction (i.e. the bubblegum). First, the addicted person gets stuck using alcohol or drugs. Then the respective family members get stuck in their attempts to help the addicted person. Once stuck, it will be hard to move around, and people lose choices in what they think and do. Only by taking good care of themselves, would members become unstuck.

Activity two.

Each child will take a turn in creating a family portrait, by choosing other members of the group to play the role of family members. After choosing the members the child sculpts or positions the selected members to create a family scene (Virginia Satir, 1981). The actors remain silent while the "sculptor" describes the various family members and how they interact with each other. Following each participant's scenario, the group will discuss the depiction.

Check-out.

Children will be asked to comment on the group session and how it felt to have the discussion directed at identifying times when substance abuse was a problem.

Journal writing.

Children will record their feelings about the person in their family who is addicted. Children will be asked to think about how it would feel if the addicted person got sober. Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. After the children leave, the facilitators debrief, record the progress notes, and tidy the room.

Session Four: Families and Addictions (part two)

Session four will be a continuation from the previous session's theme. It is anticipated it will also be the start of the working stage, according to group develop theory. Children continue to explore difficult themes, actualizing the original purpose of the group. The challenge of group participation will increase as members are expected to

work harder and become more involved in discussion, offer information and share their stories.

Objectives.

This session's objectives are to facilitate open communication between group members and dispel myths surrounding secrets of alcohol/substance abuse while increasing the members' understanding of powerlessness. A second objective will be to involve the members in an exploration of the uses of power and expand their knowledge of positive/negative options in the "re authoring" of their experiences and perspectives.

Check-in.

Facilitators invite children to offer their thoughts of previous sessions, segueing onto a review of the first part of families and addiction. The "miracle question" (Nylund & Smith, 1997) will be used as a vehicle to have the children look past the problem and into the future. Specifically, the members will be asked to consider what it would be like to wake up tomorrow not having substance abuse affecting their family. Assisting the group to imagine life without the problem is intended to give them temporary relief and more emotional freedom, during which new behaviors are more likely.

Housekeeping.

A forum will be created for discussion on any concerns relating to the group to date.

A discussion on the rules in families, how they vary, and examples of some of them will take place. These rules are to be listed on a flip chart under the categories of spoken and unspoken rules. The group will brainstorm about the confusion that often comes with these rules and what to do with this confusion and any other feelings that may

arise at the time. An open discussion initiated by the facilitators will take place on the notion that it is possible to both love and hate someone at the same time. The group facilitators will suggest that sometimes people deal with these feelings by using substances.

Activity one.

The following exercise aims at providing children with a list of important telephone numbers they can use when they need help. While compiling the list in the group session it will be emphasized how important it was for each member to have such a list. Emphasis will be placed on the numbers being used by other children with similar problems. Essentially, the children are given materials to construct their own support telephone book. The group brainstorms names of people they could turn to for help. When as many people as possible are named, the children take pencils and complete the process by documenting the information. Facilitators can assist members individually by suggesting other people they might call. The activity ends when everyone had at least five names and telephone numbers. Facilitators will encourage the children to keep the list in a safe and easily accessible place in the event of an emergency.

Activity two.

The facilitators encourage a group discussion on family rules and secrets. A list is generated from the discussion and facilitators assists the members with comparing big versus little secrets or rules in their family. Explanations as to why they believed they were big or little secrets will be sought.

Check-out.

Members will be asked for comments on this session.

Journal writing.

Group members write about feelings they experienced in this evening's session. Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. After the children leave, the facilitators debrief, record the progress notes, and tidy the room.

Session Five: Coping With Problems

Objectives.

The objective will be to hold a discussion on problems in the members' families and offer effective ways of coping with these problems.

Check-in.

Children will be encouraged to share comments on their weekly group experiences.

Housekeeping.

A reminder is provided that the group is half finished. In a discussion format, group members are invited to explore the definition of coping, and the different ways individuals cope with trauma, stress and discomfort. The discussion is to include how people choose to cope can contribute to their feelings of powerlessness and helplessness and how being in a family where there is an addiction may put children in situations that are hard to cope with. This exercise is to be complimented by examples of the situation and how to best approach them.

Activity one.

The activity for this session is exposing the children to other COAs who are now adults, and who have lived through similar experiences as the group members. The guest

will be some body who had completed Kid's Power, and was familiar with the structure and purpose of the group. The guest briefly tells their story and then the facilitators encourage the members to ask questions about their experiences.

Activity two.

Balloons will be blown up and positioned in various parts of the room. Each child will choose a balloon and designates it a particular problem or situation that causes them uncomfortable feeling(s). They pop the balloon and retrieved a piece of paper inside that balloon which outlines a situation. Finally, they will be asked to offer their thoughts on how to positively address the situation.

Check-out.

The facilitators will ask the children to express their feelings about the group meeting.

Journal writing.

Children will be asked to record or draw what kinds of situations are hard for them to cope with. Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. After the children leave, the facilitators debrief, record the progress notes, and tidy the room.

Session Six: Changes

Objectives.

This session's objectives are:

> **1)** To help children realize they cannot control or change another person, including someone they love who is abusing substances, but that they do have control over themselves. They have the power to change their own lives.

2) To facilitate the participant's differentiating between things they can change and things they cannot, and recognizing that there are people who care about them and are willing to help them. Identification of these people will be generated.

Check-in.

The facilitators encourages the group members to share their comments/thoughts on the previous session.

Housekeeping.

A reminder again will be given that the group was nearing its end. Facilitators introduce the topic of change, and what it means in various circumstances. Members will be encouraged to create a list of things they would change about their families if they could. They then are asked to explore those things that they can change and those they cannot. This becomes a list which will be used to segue into discussion about self-care techniques and using energy on things you can change (i.e. yourself). Other headings on the list might included people who care about you, what they can help you with, how to get the things you need to grow up and be safe and feeling hurt/angry about things that have happened and what to do with those feelings.

Activity one.

The children are asked to name a feeling(s) that they struggle with and a scenario, which elevates that feeling. After relating their story and feeling, they will write, draw or print the feeling on a card and take turns throwing the feeling away (piece of paper) in to a garbage bag.

Activity two.

Members will be divided into teams of three, and asked to give their teams a name. With a spin of the "wheel of misfortune" each team looks to see what problem it had landed on. An example of a problem is a parent too intoxicated to make supper. The team then brainstorms ideas about what to do with the dilemma and presents it to the remaining teams. Where group memberships were not divisible by three, facilitators and/or assistants teamed up with the children.

Check-out.

Comments on the group activities this evening will be sought from each member at check-out

Journal writing.

The children will be invited to make journal entries centered on their thoughts about this session. Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. After the children leave, the facilitators debrief, record the progress notes, and tidy the room.

Session Seven: Choices

Time will be allotted for group members to process the recognition that the group is coming to an end. It is anticipated that this session will focus on the completion of group goals and purpose. Members will be given a chance to practice their learning and translate it to other situations (Cormier & Cormier, 1985; Garvin, 1997). The group members will be prepared for the upcoming termination of the group sessions (Dimcock, 1970). The objectives at this session are providing the children with problem solving skills and a safe environment in which to practice these skills.

Objectives.

To help children recognize that, although they cannot always choose what happens to them, they can choose how they react. In acknowledging this, Kid's Power group helps children improve decision making skills and realize that they do not have to be limited by the past; that they can learn new ways to think and act. At this session members will be asked to identify their strengths and skills and the facilitators will assist with introducing them to whatever other support resources are available.

Check-in.

An exercise in silent greetings will be initiated. In this exercise the children can practice saying hello without verbal expression. This provides an opportunity to practice recognition of affect and body language.

Housekeeping.

A reminder will again be given that the group sessions are over in two weeks. Facilitators will request input from group members on how to mark the last session and make it a special time. Specifically, input will be sought on choices of snacks, activity and music.

The plan for this session is to focus on empowering the children. In other words, while we can't choose what happens to us, we can choose how we react to it. Activities on this topic include the following events.

1) Everyday situations that present themselves to us and choices we have about responding to them.

2) Decision making being hard but also the best part of being a person.

3) Making good decisions that help you take care of yourself and listing examples of these.

4) Steps to good decision making and positive and negative for each decision. The information gathered would be listed on board.

Activity.

Role-play scenarios which model problem solving strategies. Scenarios to be role-played are those that include dealing with addicted people, keeping safe, making decisions about your own substance use, etc.

Journal writing.

The topic for journaling will be the different choices that the members have had to make in the past and the scenarios that brought about the need for these choices.

Check-out.

Members will be asked to comment on the group exercise. Completion of evaluation measures will follow along with snack. Unstructured social time and opportunities to say good bye to one an other will be allotted. After the children leave, the facilitators debrief, record the progress notes, and tidy the room.

Session 8: Self Care/Good Bye Ceremony

This last session is intended to be a celebration of the accomplishments of the members in a formalized manner. It is the group's last meeting. None-the-less, the check-in and check-out routine will continue at this session. The first portion of the session will be a review of the group objectives and goals. Past group learning is to be included. The purpose of the accomplishments, future plans and healthy closure will be emphasized (Rivas & Toseland, 1998). Each child will be given the chance to write a goodbye letter outlining what he/she had learned in the group process. This is viewed as an opportunity to reflect on the group process. Members will complete the standardized questionnaire.

The remainder of the group's time will be spent presenting certificates, self-care packages and the return of journals and completed work and building of 'addiction free' gingerbread houses.

Objectives.

There will be two objectives at this last session. First, to focus on group members returning again to an individual status, recognizing their accomplishments and progress. The second objective is to process any feelings members had related to the ending of group and to assess the need to make future referrals for the members.

Housekeeping.

As part of this process, there is to be a discussion identifying future risks and the establishment of safety and self care plans. The second objective is to process any feelings members had of ending the group and to assess the need to make future referrals for the members.

Approximately two weeks post group completion, the children and their caregivers will be given the opportunity to meet with this writer. The purpose of this meeting is to complete a Client Satisfaction Questionnaire and to gather general feedback about the group experience. It is also an opportunity to follow up on their progression with the referral to collateral resources if it had been suggested that they do so.

Considerations for Facilitator Selection

Primary considerations for facilitator selection included, but were not exclusive to, the many merits of having two group facilitators (Garvin 1997; Rivas & Toseland, 1998). For a facilitator there were a number of leadership responsibilities, such as observation, interpretation and the processing of group interactions. Additionally,

facilitators managed participant behavior and facilitated family connections (Mandell et al., 1989). Hastings & Typpo (1984) recommended that a group with COAs have a low number of participants (six to eight) with two facilitators. Two facilitators have more time to address the individual member's needs. Two facilitators can more easily set time aside for the group process and time to alleviate any one member's competition for limited resources. Two facilitators share the responsibility of preparing and tidying after group sessions.

Other advantages of co-facilitating are opportunities for conjoint evaluation, skill learning and debriefing (Mandell et al., 1989). Organizations often consider time and cost factors when assigning employees to group work, and frequently opt for the least expensive route. In seeking an alternative to this, volunteers were utilized to off set costs and provided training skills for others. Many professionals benefit on several levels when volunteering time in exchange for an educational opportunity.

The co-facilitators met at regular intervals to plan for the group sessions, to review and debrief sessions, and to discuss transference issues, enhance communication and review the successes observed (Rivas & Toseland, 1998). Regular meeting times were useful in assigning tasks, roles and activities to each facilitator and helped build a mutually supportive and trusting relationship between co-facilitators (Poey, 1985; Rivas & Toseland, 1998). As well, facilitators developed working relationships and consolidated their successes. Finally, consistent supervision by an outside member assisted facilitators in examining missed issues (Poey, 1985). However, in this practicum the expectation was that this writer carried the majority of the responsibilities, as an opportunity to learn, enhance skill development, and engage in self-reflection. This writer

was joined by Ray Babb, B.S.W, in the role of co-facilitator for both the Tuesday and Thursday groups. Mr. Babb was recruited for this role on the basis of his experience and knowledge base in working with children and their families. Additionally, Irma Pangborn, B.S.W initially provided collateral support with the Tuesday group, complemented by volunteer, Debra Figowy and social work student Maggie Yaboah. These extra supports were secured anticipating that the behavioral dynamics of the membership may require one on one intervention to manage the participants effectively.

Facilitators met weekly to discuss, plan, prepare and record progress notes. Following each session, facilitators met to confer and debrief the sessions. Again, as in many group processes, facilitators were viewed as equal partners throughout the process. Facilitators and volunteers participated in the group sessions, processing group dynamics, guiding group interaction, managing group conflict, and presenting material and facilitation activities. Also, they contributed to closing summaries and were present at all closing interviews.

Kim Clare, M.S.W., advisor, and professor, at the University of Manitoba/Winnipeg Education Center provided clinical supervision for the group intervention through observation of the group process and verbal consultation and feedback. This writer's practicum committee consisted of Kim Clare, M.S.W., faculty of Social Work advisor, David Sullivan, M.S.W., Director of Marymound, Inc., external examiner, and a third examiner, also from the University of Manitoba Faculty of Social Work, Dr. Brenda Bacon. Committee members provided guidance and feedback on the intervention process and on the evaluation components of the program. Additionally, the committee reviewed written reports and participated in committee meetings as required.

Supervision ensured that the group facilitator met the protocols of Marymound, Inc., in areas such as documentation, file recording and reports. Legal guardians of members were required to sign a consent form allowing participation in and for videotaping of the group. Similarly, facilitators signed a confidentiality agreement adhering to the ethical protocols of Marymound, Inc.

Selection of Membership

Careful screening prepared group candidates for their involvement in a group process. Screening maximized the success of a group process, eliminated inappropriate participants and ensured a successful group (Mandell, et al,. 1989). In assessment of potential group members, this facilitator examined several factors. These included concentration and ability to respond to direction; the developmental level of the child, his/her presenting behaviors; his/her ability to communicate regarding their experience with alcoholism; current coping skills; connection to outside resources; and any previous group experience. A thorough psychosocial assessment was not an affordable option but refining the selection process occurred in preliminary screening and a referral form was used to do this (Pilat, 1987). Referrals to the group were open to social service agencies throughout the province. The referring agent was responsible for the transportation of the child to and from group. Written consent for group treatment and participating in the studies of a master of social work student, as well as any other ethical guidelines as outlined by Marymound Inc., were secured in pre selection interviews.

Several children who were developmentally or academically delayed had some difficulty completing writing exercises, but visual stimuli were utilized as a replacement tool (Mandell, et al., 1989). Inclusion of caregivers in the interview process provided

collateral information and engaged parent/caregiver support for the group process. Personal interviews conducted with potential candidates served two purposes: assessment and preparation. Interviews permitted facilitators to assess the child's potential to respond to limit setting and his/her behavioral controls. Additionally, the facilitators evaluated the children's capacity to take turns and follow basic rules, which would impact on the group process.

Each child and his/her caregiver were invited to participate in a pre-selection interview. These were brief in duration and focused on assessing the child's appropriateness for the group. Also examined was the degree of caregiver support and collateral resource support (i.e. therapists) for the group. Interviews permitted the children and caregivers to determine whether such a therapeutic resource was applicable to their needs and whether they wanted to participate in the intervention. Interviews gauged the potential participants comfort level with the topic and the facilitators.

Mandell et. al., (1989) recommended using the initial interview with children as an opportunity to prepare the group members for the group process. Children benefited in several ways from this orientation experience. In orientation, the children were told what the group would be about, met the facilitators and received an explanation of group themes and an outline of the group format. Supplemental data on the potential participants was elicited with the utilization of further screening questions (Appendix B). Additionally, the children and their caregivers were told that this group was a practicum project and that they could choose not to participate. The writer informed the individuals involved that the information collected from this group would be compiled in a final report and that the participants were welcome to read the report if they wish to do so.

Further, they were told that this project aimed to protect confidentiality and privacy of those involved. Legal guardian(s) were asked to sign a permission form outlining these points, and giving permission for participation in Kid's Power, including videotaping of sessions to be used for educational purposes only (Appendix C).

Preparation reduced anxiety for the children and offered the caregivers and the children the assurance that the facilitators would protect and support the children in the group. Interviews prepared children for the eventuality that they would be invited to talk about substance abuse in their families and how it has affected them in the group environment. At the same time, children were assured that this will only occur when/if the child felt comfortable enough to do so. Facilitators included a designated time for debriefing, planning activities, writing progress notes and reports in their group preparation (Mandell et. al., 1989).

Another phase of preparation addressed the issue of respecting privacy and confidentiality. The privacy of the children was respected relative to any confidences they disclosed. The children were advised that the rule was followed by everyone; that being "whatever is said in group, stays in group". Children needed to know that they can trust the facilitators and other group members to respect confidences shared in group (Attinson & Skolnik, 1978; Mandell et. al., 1989). At the same time, children needed to know that disclosures of abuse would be reported as required under the child welfare mandate. Caregivers were notified to encourage children to respect the confidences shared in the group forum. The children were permitted to discuss their own situation if they choose.

The facilitator guided the participants through preset group modules, in a format that increased the children's understanding of the context of their behaviors. The group structure mirrored and modeled the skills and techniques necessary for the children to modify their own responses and behaviors.

Referral requests were sent approximately one month prior to the commencement date of the group allowing time for response and pre selection interviews (Mandell, et. al., 1989; Rivas & Toseland, 1998). Response was rapid once flyers were sent to different agencies, with no in-person information sessions required to encourage referrals. Approximately 16 candidates were referred for this service. Two of the candidates were initially rejected based on their age. Fifteen candidates were selected based on the established criteria, and invited to participate in a pre selection interview. Three clients declined to attend the group. One of these children had just returned home from foster care placement during the period that the referral was made and pre selection interviews were set up. Her parents did not support her attendance in the group. The other two indicated they were not prepared to attend, although they were encouraged to make an attempt. However, during the first session the participants' behavior was unmanageable and compromised the safety of the remaining group members. Consequently, their participation was discontinued. Sibling sets were referred. Whenever possible they attended different groups from one another. However, this was not always possible. There were four sets of biological siblings and one dyad that resided together in the referrals received. Due to scheduling contradictions and limited transportation resources, two of these sibling sets and the dyad attended the same group. In total, five children attended the Tuesday sessions and seven attended the Thursday sessions.

A Comparison

Having two groups running concurrently was both interesting and challenging. Each group had its similarities and differences to the other. Likenesses between the Tuesday and Thursday groups included that all participants were residing outside of their birth homes in alternative care. This included foster care, extended family care or being in the care of friends. The alternative care status of the participants was neither predicted nor restricted. The one child whose living status changed prior to the start of group ultimately was not supported by her birth family in participating and did not attend the first session.

As indicated in the module outline, the intention had been to have the groups move through the sessions at parallel paces utilizing set activities. Additionally, the plan was to separate sibling groups with the goals of avoiding such dynamics as dyads. Group membership was to fall into the minimal basic guidelines encompassing age range, living situation and willingness to participate. Finally, sessions for both groups were to take place in the same consistent setting. While logical in theory, reality dictated some understandable but unforeseen differences emerging between groups.

Initial differences emerged when the selection for membership was undertaken. While attempts were made to strictly adhere to the original guidelines, a series of issues evolved which made strict adherence impossible. Once the screening process was complete, it became apparent that only a limited number of participants fit within the expressed guidelines. This presented potential problems related to attrition, and developmental appropriateness. Specifically, if membership began on the lower end, attrition may lower numbers to an undesirable level altogether. Consequently,

applications initially ruled out of consideration were reconsidered; this resulted in the content of membership involving a more varied range of participants than initially anticipated. This was especially true when comparing the two groups.

Tuesday's group had a much closer range in age and developmental skills. While chronological ages ranged from 9 to 13 years, the developmental range was much more in tune with that expected in the original 8-11 age spread.

Thursday's group age range was broader spreading from 6-13 years. Developmental ranges amongst this group were also more extreme, in that the 13 year old had no developmental gaps while the six year old and one of the eight year olds were delayed, increasing the range across the group.

The vast range in developmental differences served to strengthen both groups rather than weakening the groups, as initially anticipated. These differences created opportunity for support amongst the membership. This was seen in the comments made by the children and in the children's efforts to assist those who requested help; the assisting behaviors in turn enhanced the children's learning. Less healthy alignments flowed into more productive ones and mentoring relationships were developed. The benefit to the group as a whole was unanticipated but remarkable. Unproductive alignments were negated with cohesiveness being the final result. In hindsight, these roles certainly suggested a parentified function, which many of the children are familiar with from their families. However, unlike the family dynamic, both sides of the dyad gave and received from each other in different ways. Specifically, in that many of their issues and experiences related to addictions are similar, both parties offered equally

valuable insights and in several instances were able to teach each other regardless of their age or academic differences.

The dynamics of the respective groups were also more incongruent than originally intended. This was particularly evident in that of the total number of referrals received well over half were sibling dyads. While one dyad was not related, rather residing together, they functioned essentially as siblings. Splitting these children between groups to avoid the dynamics potentially inherent in this situation became complicated. In the end, this could not be completely achieved because of time and transportation conflicts. Consequently, Tuesday's set had no biologically related dyads, while Thursday's had a sister dyad.

Dyadic issues between groups resolved themselves. Tuesday's set had two members living together who engaged in the triangulation, splitting and conflict typically found amongst sibling pairs. Thursday's sister set posed much less of an issue than first anticipated. One of the girls was quite independent and her sister's efforts to engage in disruptive dynamics were essentially ineffective. The remaining sibling pairs were split amongst the groups. No objections were raised with this. To the contrary, many children expressed relief and even delight.

The groups differed in their module content in spite of the original intent. What evolved as the sessions progressed was that the Tuesday group, the first group to be led through the original module, began to serve as a testing ground for the material. When something did not go well or was too difficult, the module was modified for the upcoming Thursday group. Discrepancies resulted between the groups in terms of the ability to make general comparisons because the content and sequences were no longer

wide spread. This relates specifically to the activities utilized rather than the sequence of topics.

For example, during session three one of the proposed activities was the "bicycle game". When initiated with the Tuesday group, the game appeared to either be beyond the comprehension of the children or to simply fail to secure their attention. Consequently, Thursday's outline was modified, allowing for the elimination of the bicycle game.

A similar dynamic emerged out of the relatively consistent difference between groups. The Tuesday group progressed through the material with fewer effective distractions and storming. This often left extra time in which a game of tag or other socializing activity could be initiated at the end of the session. Thursday's participants exhibited much more storming, triangulating and regressive dynamics. As a result more energy was expended on maintaining cohesion and redirecting energy. This often dictated that the children had to work until the last minute to complete the material. For the most part the activities that worked well with Tuesday's group also worked well with Thursday's group, although not necessarily in the same sequence. For instance, it proved to be productive for the Thursday's group to eliminate the "Bicycle Game" from the originally scheduled session and place it into a later session.

The journal writing activity proposed was not initiated at all in either group. While sound in principal, for both groups the structure of the activity was consistently commented on as "to much like school work". The therapeutic benefit intended was invalidated by this perception. Thus journaling was quickly eliminated from the repertoire of activities. Similarly, the letters intended to bridge time between sessions

were also modified. Rather than written content, visual aids were improvised. These included cartoons, copies of symbols or portions of activities completed. This minor alteration took away the homework flavor of the activity while still getting the message to the children. For instance, following the session dealing with coping, an envelope with '3 C's' was mailed out to the children, as a reminder of the adage that they didn't cause, can't control or cure the addict's behavior. For the most part, these participants were more inclined to action versus processing.

Altogether, the progress of the groups was congruent. Both evolved through the beginning, middle and termination stages of group development in the number of sessions provided. The difference lay in the pace. Pace was dependent on the alignments, and behavioral responses to the material presented. In short the outcomes were the same but the process differed between the groups.

Value of Chosen Model of Intervention

As previously noted, this group intervention was based on a series of theoretical models. These included psycho-educational, cognitive, solution focused and narrative theories. Small group work theory supplemented these approaches. The following discussion delineates the usefulness of these chosen methods. Elements of these theories were incorporated into the group modules and activities to assist in changing group members' perceptions, responses and sense of self in relation to substance abuse in their families of origin and in their own capacity to make different choices. Many of the activities employed within the sessions incorporated more than one of these perspectives.

A psycho-educational approach was employed in every session by virtue of the information offered which was then discussed within the group. This consistently led into

experiential exercises, which gave the information a context in which to be played out (Anderson et. al., 1986). This prepared the children for utilizing the information in a number of different but related situations. For example, in the first session discussion about stereotyping the image of substance abusers was held; then a collage was created depicting these perceptions. This was followed by explanation for each for the choices utilizing a psycho-educational approach. Additional activities that fall under a psycho-educational perspective included the listing of issues on flip charts, the watching of videos as well as having a guest speaker, all of these activities were followed by discussions and brainstorming.

Cognitive theory was also employed throughout the intervention. The purpose was to provide different scenarios, all related to the issues that the group was addressing, thus facilitating the development of alternative self-concepts. The members' concepts were challenged in this setting. This effort served to change dysfunctional or stagnant thinking processes. In turn, cognitions were altered and new options and perspectives developed (Bernard and Ellis, 1983).

Many cognitive distortions related to addictions and the secondary concepts and issues revealed themselves in this population. The children all struggled with internalized cognitions about healthy/ unhealthy coping, inappropriate behavioral responses to stressors associated with addictions and the stigmatization related to having addicted family members. Cognitive theory introduced a way that reframed the thinking surrounding the children's experiences and responses, allowing the children to progress to a stage where they could reorganize their coping responses. During the first session, a stuffed elephant was placed in a chair. As the room filled up, the elephant was moved

several times to make room for participants. However, no one ever asked why it was there, taking up space that was required for participants. Rather, the elephant simply kept getting pushed away and ignored despite the need to constantly reorganize the room around it. When this was pointed out to the participants, it opened the possibility of discussion, generating ideas about addictions too always causing problems and adjustments but never really being talked about. Moreover, participants were able to challenge this response to the elephant/addiction and reconsider alternative ways to address it and the outcomes that might result.

Cognitive theory presented facilitators with an understanding of maladaptive thinking patterns and how to change these patterns. In this group the children benefited from an experiential learning format. The sensitive nature of the topics was often met with avoidance, but the children always participated in "hands-on" activities helping them to learn the tasks at hand. The children were able to use the group in which to practice their newly learned way of thinking, for example, the use of the 'three C's' (cause/control/cure, none of which children are responsible for in an addicted person). These same 'C's' were repeatedly brought back to the participants in mail outs between sessions and reviews to remind and review with participants the restructured perspective.

Participants were provided the chance to play out any number of personal experiences relating to family members' addictions, but an alternative spin was provided to the member's perspective. By removing the child's sense of having to take some responsibility for others' choices, the children were able to realize that their decision and responses must only be based on themselves rather than others (Freeman, 1987). Consequently, the responses to this perspective lead to different standpoints accordingly

altering thought processes and eventual responses. For example, the child begins to see that doing what is best for them is paramount rather than attempting to take responsibility for others.

Internalizing the meaning of the "three C's" helped the children become aware of the cognitive distortion in their typical response to a chronic situation. Problem solving skills could then be revised, and alternatives examined. Reframing, and changing perspectives become the means by which coping skills are adapted and the cycle of dysfunction can be broken. The restructuring skills are then provided with a context in which to test these alternatives (Barth, 1986; Cormier & Cormier, 1985), such as in "The Wheel of Misfortune". A variety of scenarios are provided, in a competitive and fun context. Children can then generalize the skills learned to any number of potential situations to generate alternative and ultimately healthier and self preserving responses (Cohen & Schleser, 1984). Also included in the cognition related category would be activities such as "The Bubble Gum Game" and "The Bicycle Game".

Paralleling this effort, strategies rooted in Solution Focused Theory integrated an empowerment perspective urging the child to gain a perspective of him/herself as the expert (Peller & Walter, 1992). It focused on the future and how it can be different when one assumes an alternative perspective. Energy snowballs, as was seen in the brainstorming and team based efforts of the children using their new perspectives to generate any number of choices. Each choice was child focused and different from the previous one. In this participants were supported in taking control of their experiences and outcomes, and recognized themselves as their own best source of decisions (de Shazer, 1988).

Examples of the use of Solution-Focused Theory included the activity in which the group brainstormed a "phone book" list of resources for themselves that could be useful should they find themselves in an unsafe position in the future. Only the children can generate these lists as they are the ones who know who is dependable in their lives. This realization, when highlighted, serves to emphasize the actual degree of power and control the child has over him/her self. It was affirming to know there are people you can depend on. The same is true in the activity of brainstorming the definition of coping. The very definition of coping implies that there are ways to deal with issues that will allow the children to be less affected by substance abuse in the future. This implies hope that addiction will not always be the predominant issue that it has been, and assumes that in the future with these skills, it will not be the child's issue at all.

Another activity embracing this concept was the Bicycle Game, which entails the participants each taking a seat amongst the many chairs lined up to form a bicycle. The participant in the first chair is designated as the driver, as well as the person with an addiction, therefore having control over those riding behind her/him. As the 'ride' begins, the pace of the 'ride' picks up and grows increasingly out of control. During this progression the riders are asked to state their feelings about the ride and to make a choice about whether to stay on the bicycle or jump off, even though this move may result in someone getting hurt. These are but a few examples of how Solution Focused Theory had been integrated into the modules to effect change in the participants.

Paralleling cognitive theory, narrative theory is similar to Solution Focused Theory, in that it maintains that the client is his or her own best resource (Hastings & Typpo, 1984; Freeman & Combs, 1996). Its actual use is slightly different in that it

externalizes problems, allowing them to appear more controllable and less personal, thus less sensitive (Nylund & Smith, 1997). In doing so, the road widens for clients to see alternative interpretations of situations and therefore provides a wider range of solutions to a problem.

Narrative therapy was an approach that offered the children a chance to talk about very sensitive and potentially threatening topics. The narrative perspective introduced an externalized way to address these topics and issues. As suggested by narrative therapy (Epston et. al; 1997; Epston and White, 1990) the facilitators introduced brainstorming, art and drama as ways to discuss sensitive issues and situations related to substance abuse. The children responded to these strategies with enthusiasm. They were able to attach their own meaning and express themselves in ways that made sense for them. The facilitators composed weekly mail outs to the children that provided an overview of the previous group session, roles and themes. Though originally intended to be written in content, this was quickly modified to strictly visual inserts. The purpose was to connect the participants to the previous sessions' theme and prompt discussion. For instance, the session that incorporated the analogy of addiction and being stuck in a wad of bubble gum, a single piece of bubble gum was mailed out. Upon receiving the mail outs, several caregivers contacted the facilitators to advise that the children had delighted in receiving the treat. When asked by their caregivers what the purpose of the mailing was the children were able to engage in an explanation and dialogue about the analogy. Further, when the participants arrived for the next session, they often began by engaging each other in inquiries about the mail out. These mail outs seemed to connect the participants to the group process and themes discussed, serving as a review and a reminder for the

members of what had transpired in the last group session. At the end of the group sessions, the children were provided with a set of materials, primarily art work, outlining the themes discussed and addressing COAs specific needs and concerns. This seemed to be helpful to the group process, providing a safe way to build cohesion, strengthen positive roles and emphasize healthy coping options. This approach encouraged the children to seek their own meaningful ways to empowerment, to redirect their own choices and to take control of their lives.

Seen in the dramatization of the problem of addiction in "The Bubble Gum Game" is the analogy of the principle of getting 'stuck' in a wad of gum with addiction to a substance. Each child attempted to help the increasing number of folks who become stuck due to their stagnant perspectives and inability to cognitively restructure a perspective of their role and responsibility in the situation. It allowed the participants to actually visualize the mess this creates without placing blame or judgment. Instead of placing the blame, the children could simply see the pattern, and recognize how this changes when alternative responses are generated. The alternative responses come from the luxury of being able to place the situation at arms' length and discuss it without it being personal. Perceptions, cognitions and alternatives, can be more clearly seen and responded to when heightened emotions are not generated. Inherently, the children recognized that they have the control and capacity to shape their own actions and that they can take control in places they otherwise assumed they could not (Kral, 1989; Freemen, Epston, Lobovits, 1997). In this example one can see elements of cognitive theory, and solution focused theory complemented with a foundation in narrative theory.

Treatment groups provide participants with many advantages such as support, education, growth, socialization and therapy. Children coming together in a treatment group have the advantage of making connections with others (Rivas & Toseland, 1998). Children from families in which there are substance abuse issues are often isolated, ashamed and friendless because of the havoc this creates on their lives. The intervention offered in this practicum provided a group of children with the opportunity to resolve past experiences, to make new friendships, and to practice a wide array of healthy and novel means by which to cope.

Members in the group settings received validation, and self-understanding. The group mirrored healthy interactions and alternative perspectives, respect for others and encouraged positive self-esteem. The children explored confusing and often scary experiences in a setting that was validating, supportive and safe (Mandell, et al, 1989). At the same time, the group gave children a safe and supportive environment for practicing their new skills and an opportunity to externalize these to the outside world. The use of the 'neighbourhood board' to open each session in an example of this. With a new symbol representative of themes used each week, a different participant each week was encouraged to place the symbol on the board which depicted a generic neighbourhood and its physical layout. Depending on the theme of the session, the participants would be asked to select a position for the symbol and explain to the group why they chose this position. The board was used as a neutral arm's length focus for the participant's to discuss sensitive topics and exchange ideas about how to practice and translate these thoughts and decisions to the world outside of group.

Group treatment appeared to be the optimal intervention for this population as it decreased isolation, improved social interactions and provided a setting for children to address their experiences and lives in a nonjudgmental setting. The value of group therapy is well documented in the literature by such authors as Rivas & Toseland (1998) and Rose and Edleson, 1987).

As suggested in the literature review, the group intervention had many positive effects for the participants. The group process enabled both peer group support and challenges. The group offered a means to assess and evaluate changes in thinking and responding. Hird and Morrison's (1996) conclusions about the positive benefits of group work were confirmed. The children in this group relayed that attending the group offered them hope and validated their experiences. The group acted as a catharsis for the participants to have an interpersonal learning experience. Utilizing a multiple theory based group intervention gave these children an opportunity to decrease their feelings of responsibility, develop positive cognitive strategies, restructure distorted thinking, build support and improve their sense of having some control and power.

The group offered these children a sense of belonging, worth and competence. Latency aged children were aided in accomplishing the many challenging tasks required of them, including forming a healthy identity, preparing for the future and developing moral value systems (Malekoff, 1997). The group was a supportive and safe place for corrective experiences, to learn new skills, to practice decision-making and to provide the availability of support long after the group terminates (Malekoff, 1997).

It was observed that this group intervention proceeded through the expected developmental stages. Group members formed a cohesive and supportive bond with each

other. The group advanced to a level where they trusted each other enough to disclose personal and intimate stories about their families. Even with young children, it is noted that a group of peers can provide mutual learning and support to each other. The group also gave the participants a chance to practice new problem solving and coping skills and further integrate their learning. The groups helped these children form friendships and feel less isolated about their experiences and ongoing struggle with addicted family members.

Client Profiles

This writer met with two sisters (A. and AA.) at their current placement, which was an emergency shelter. The girls had been there approximately three months. Their primary caregiver was struggling with alcohol abuse, and the children themselves requested placement in care.

A., the older of the two, presented as being her chronological age of twelve years. Outside the age range for the group, she had been invited to participate in the interview along with her sister by the referring social worker prior to the actual referral being made. Although aware of the plans for the group and the meeting of facilitator, A. was very reserved and shy. She spent the initial part of the interview holding a pillow to her face. She did eventually warm up and participate in some of the discussions closer to the middle of the meeting. She did not offer a great deal of insight into herself or her thoughts about her situation, but was happy and agreeable about coming to the group.

AA., who was ten years old, presented as her chronological age. AA. was very verbal and outgoing, and chattered away with the interviewer for the duration. She was open about her current reasons for being in care, and was keen to participate in the group.

She was "scattered" but was able to concentrate and process the information posed by the facilitator.

Two other girls (B. and BB.), aged nine and eleven respectively, were screened together as both attend and live at a group home sponsored by Marymound, Inc. and were available at the same time. Both easily participated in the exchange of information, although it seemed unclear whether they fully comprehended the details offered. They were basically communicative and able to ask the interviewer questions about the upcoming group, such as who else would be there, the age range and what snacks would be available. They responded appropriately to questions about their likes and dislikes, and the group expectations. At times, they appeared to be mentally distant and did not make eye contact to any great extent regardless of whom they were talking to. Their affect was fairly flat and difficult to read in conjunction with their statements. Both were agreeable to attending the group and understood that other adults may be observing in order to learn more about how to help children.

C., was aged ten, and interviewed in her home along with her caregiver/aunt. She was extremely expressive and socially competent, interacting well with the interviewer in discussing her hobbies her strengths and weaknesses, and her preparedness to attend group. She looked at her aunt on several occasions for reassurance when answering questions, which was very encouraging and appropriate. C. appeared relaxed in her manner. She spoke openly about how her mother is struggling with cocaine addiction. She was equally comfortable speaking about her mother as well and was very agreeable to attending and participating in group sessions.

D. and DD. were also sisters residing in emergency shelter placement at the time of the pre screening interview. Their primary care staff attended the interview with them. Both girls were fairly open and outgoing, and bore a close resemblance to each other. They were aware of the meeting and prepared. They did not seem to be hesitant or anxious about the process or the group.

D., at age ten and the older of the sisters, appeared younger than her stated age. She was initially assumed by the writer to be the younger sister, but was corrected. She was the quieter of the two, although she was relatively articulate and able to interact and provide information as requested. She presented as somewhat developmentally young and possibly immature relative to her peers. She was willing and able to attend the group. She seemed much more thoughtful and less quick to respond to questions, as though she was thinking her response over carefully. She was noted to be not as excitable or distractible as her sister was.

DD., aged nine, was initially thought to be the older one. She was taller and somewhat more developed in her appearance than her sister was. She was also the more outgoing of the two sisters, appearing to be more spontaneous and outspoken. At times, the interviewer thought this might be an inability to concentrate for longer periods of time. She was easily redirected, although this was frequent. She too said she was willing and keen to participate.

Two male siblings (E., EE.) were interviewed at their foster home, along with their foster mother. Each boy was interviewed separately because of the alleged tendency to overwhelm each other and bicker over their different perceptions of their experiences in their birth home.

E., at age eleven was an articulate child who appeared to be his stated age. He appeared appropriately reserved initially and warmed as the process proceeded. He interacted with interviewer well, asking appropriate questions about programming and details. E. presented as being fairly mature and responsible, and developmentally on track. For example, he gave a number of examples of school work he had just completed and attended well to the questions being asked of him. He also attempted to assist his brother in refocusing when he became distracted during his own interview. This was consistent with the description of him being the parentified child in the family, taking over when his parent was intoxicated. He was willing and prepared to participate in the group.

EE., age nine, presented as younger than his stated age. He was very cuddly and affectionate with his foster mother, who seemed to be quite attuned to his moods and needs. Easily distracted, EE. often jumped up from the interview and checked out different areas in the room. He had to be redirected and reengaged on several occasions, although he was able to process and articulate his concerns. He expressed some concerns about being made fun off or being teased by other group members, but was able to work with interviewer to put together scenarios around dealing with this and what the roles would be. He was agreeable to going and participating; it seemed EE. was content and happy.

F., age 11, was interviewed at school. He presented as a very anxious child, who was leery of the interview, though his foster mother had briefed him the previous evening. He was described as being very anxious, and difficult to manage without Ritalin. F. listened and provided information when asked, however he needed prompting to do so.

He made little if any eye contact. He was also agreeable to attending and trying the group out. He asked several times for details to be reviewed, and then repeated them to himself.

FF., although the older brother at thirteen years, presented both physically and socially as being younger. His verbal interactions during the course of the interview seemed minimal and complacent, and he made little if any eye contact. FF. appeared to be almost fragile in his stance and flat in affect. He confirmed his having been advised of the pending group by his foster mother, and indicated a passive agreement to attending, if he did not have to participate in discussions.

The remaining candidates, G., H. and HH, and I. were not interviewed in person due to distance and time factors, although this writer did speak to the potential members and caregivers by phone. This was primarily due to the fact that G., initially fell well outside of the age range at six years old, while H., HH. and I, aged eight and ten and eight respectively, were last minute referrals who did not attend beyond the first session.

The decision was made to include the six year old, along with A., aged twelve, to compensate for anticipated attrition of group membership. A., FF., and BB. all exhibited developmental delays placing them socially and emotionally within the range of membership, contrary to the chronological age requirement initially outlined for the group participants. For these last three children, acceptance into the group at a fairly late date relative to the start date made preliminary interviews unfeasible.

Group assignment, either Tuesday or Thursday, was dictated by whether a sibling was also going to attend, and if transportation was available. This was relevant because referrals included four sets of sibling pairs, and one dyad residing together within a facility, though not biologically related. Due to limited transportation availability and

scheduling conflicts with extracurricular activities, two of the four sibling sets and the dyad sharing a placement attended the same group. As per the tables below, Tuesday's group membership included; B.,BB., D., E., FF., and H.. The remaining referrals A., AA., C., DD., EE., F., G. and HH, and I., completed the Thursday membership.

Table 1: Client Profile Summary for Tuesday Sessions

	Age	**Gender**	**Current Living Situation**	**Issues Noted**	***Siblings***
B	9	F	Foster care	FAS/FAE	*dyad*
BB	11	F	"	-	*dyad*
D	10	F	"	-	*½ sibling set*
E	11	M	"	-	*½ sibling set*
FF	13	M	"	FAS/FAE	*½ sibling set*
H	*8*	*M*	"	*did not attend beyond 1st session*	*½ sibling set*

Table 2: Client Profile Summary for Thursday Sessions

	Age	**Gender**	**Current Living Situation**	**Issues Noted**	***Siblings***
A	12	F	Foster care		*sibling set*
AA	10	F	Foster care		"
C	10	F	Foster care		-
DD	9	F	Foster care		*½ sibling set*
EE	9	M	Foster care	FAS/FAE	*½ sibling set*
F	11	M	Foster care		*½ sibling set*
G	6	F	Foster care	FAS/FAE	-
HH	10	M	Foster care	Did not attend beyond 1st session	*½ sibling set*
I	*8*	*F*	*Foster care*	*Did not attend any session*	

Attrition, Attendance and Participation

At the first session of the Tuesday group, H. did not attend. Two of the participants arrived late to the session. The absences were later explained: a miscommunication in the case of the absent participants, and a transportation problem in the case of the latter. At the first session of the Thursday group, four of the eight members attended. One member, HH, declined to enter the room in which the activity was taking place and decided to withdraw from the sessions entirely. I. did not arrive, and it was later clarified that she had returned to her mother's care. Her mother declined to give consent for participation and consequently, and the child was also withdrawn from the group. However, two of the missing participants from the Tuesday group arrived to participate in the Thursday group, bringing the total presence to five in Tuesday's group and seven in Thursday's group.

Tuesday sessions included co-facilitators Ray Babb, B.S.W and Irma Pangborn, B.S.W., in conjunction with the writer. Due to a change in employment, Ms. Pangborn assisted with the first two sessions, and then terminated her involvement there after. Social work student Maggie Yaboah and volunteer, Debra Figowy assisted the Tuesday group with practical matters and support. The Thursday sessions were exclusively co-facilitated by this writer and Ray Babb, B.S.W. With the exception of Ms. Pangborn, facilitators and assistants were present as expected at every session.

Co-facilitators met weekly to discuss, plan, prepare and record progress notes. After each session, facilitators conferred and debriefed the sessions. Ray Babb was involved throughout the group process. He took an active role as facilitator, processing group dynamics, guiding group interaction, managing group conflict, presenting material

and facilitating activities. It was understood that this writer would be designing the content and structure of the sessions, taking the primary role as facilitator. Ray Babb, as "co-facilitator" served to assist in observing and providing input during the sessions. Attendance and participation was good. No group members discontinued their involvement following the first session. Tuesday group attendance was near perfect, the exception being D. who missed the sixth session due to a miscommunication about the relocation of her living quarters.

The Thursday membership had a similar pattern. DD. missed the sixth session for the same reason as her sister, D., from the Tuesday group. Additionally A. and AA. missed the same session due to inclement weather that prohibited transporting them safely. C. missed the seventh session due to illness.

A description of group development and dynamics for both Tuesday and Thursday session is outlined below. It should be noted that the facilitators and group issues commented on were similar for both groups. Rather than repeating the comments, they have been included in the Tuesday group's documentation, and apply also to the Thursday Group. The same is true for the "Neighborhood Board", an activity which was utilized at the beginning of each session in both groups. The response to the "Board" was similar in both groups.

Tuesday Sessions

The first session exhibited how the group members began to move through the steps of getting to know each other and the facilitators, acknowledging the purpose of the group and learning to trust, which was the theme of the meeting. The membership began the meeting expressing some variation in feelings and behaviors, each child indicating

their level of hesitance and unfamiliarity and possibly anxiety levels. All of the children remained separate and apart from each other, and for the most part were quiet and/or withdrawn initially. Most conversation and attempts to communicate came from the facilitators. Those children who spoke did so very quietly.

Initial introductions were made briefly due to the interruptions and late arrivals. The neighborhood board was introduced. It was a large poster board with a picture of a main street in a generic neighbourhood, including apartment houses, houses, stores and other common landmarks. It was explained to the participants that at the beginning of every session, one participant will have the opportunity to select placement of the icon for that session. Each session will have a different symbol representing the theme of that session. In this first meeting, a picture of a set of children recognized for their bravery for attending the program was acknowledged by showing and talking about a problem of children who were portrayed as brave. Unfortunately, in the disorder of assembling, one of the introductory exercises, "Go Round" (Duffy, 1994), was inadvertently omitted which likely slowed the warm up process. Through out the seven sessions members were observed to demonstrate increases in the level of interaction and trust amongst the membership. At least two of the children offered insights and personal information about their experiences and perceptions. These children contributed in a careful and quiet way. FF. offered little verbal participation, but did complete all the tasks asked of him. By the end of the session, this member would offer some ideas if prompted, but was very withdrawn and difficult to hear. B. and BB. arrived late, and appeared to have some difficulty settling in. They giggled likely because they were sensitive to being the late ones. For the most part, these two knew each other prior to the session and aligned with

each other. While completing the tasks asked of them, they participated minimally in the verbal sharing of experiences and information. By the end of the session, one girl was contributing, albeit inconsistently, relevant information to the topic at hand. Both tended to offer unrelated comments or none at all.

In particular, B. and BB. seemed the most limited in their functioning and ability to engage and comprehend the discussion and activities designed to bring abstract ideas together. For example, B. physically distanced herself outside the group. BB. required ongoing redirection and appeared unable to make the connection between the collage activity and its purpose (perceptions of addicts physical appearance), and her own family of origin issues. Co-facilitator, Irma Pangborn was able to provide direct supervision to this pair, apart from the remaining group members. The participants appeared at this point, to have no difficulty with the emerging normative and expected group behaviors. This may have related more to the process of getting to know each other, being somewhat hampered by the disorder that ensued and not yet being comfortable enough with each other to feel at ease and focus on the task at hand.

With the exception of the first activity, the group participants accomplished most of the agenda for the first session. These objectives included defining acceptable group behavior and guidelines for monitoring behavior and keeping confidences, getting to know each other, and feel more comfortable through sharing common experiences, and discussion of the effects of substance abuse on the body. Activities facilitating achievement of the goals included name tag decoration and the creation of a collage of magazine pictures. The participants used the collage to portray people with addictions.

The allotted time frames for each topic and activity were somewhat off and this resulted in activities being rather rushed.

It was clear in this first session that the group participants had a wide range of levels and abilities, socially, intellectually and developmentally. For example, two of the members were able to express themselves eloquently and verbalize their comprehension of the abstract connection between ideas and analogies. This was evidenced in A.'s personal anecdote that "everyone in my family drinks too much...my mother, my grandmother, everyone". E.'s comment "my dad is still drinking but he's trying not to" was equally telling. One child appeared to have the potential to verbalize his comprehension, but remained withdrawn from the process for the duration of the session. The remaining two children were completely disconnected from the process at times and had a limited ability to read, write or concentrate on the topic at hands. This was seen in their comments as well as in their behavior which included them wandering around the room while asking questions unrelated to the conversation at hand. Interestingly, as the group drew to an end, all the children began giggling and taking advantage of the snacks offered at the start of the session. The food was previously untouched and this may have been indicative of a successful transition through the comfort and trust issues. One of the members had begun to nibble initially, but stopped completely when the other participants arrived. These observations seemed indicative of participants being characterized by caution and tentativeness at the beginning of group sessions, and then engaging in an approach-avoidant conflict (Toseland and Rivas, 1998).

The role of facilitator at this first stage was to educate, establish appropriate guidelines for interactions, and model and reinforce positive social behaviors (Dimock,

1970). Tasks included stimulating interaction between members and finding a balance between differences and commonalties. Facilitators anticipated the testing of limits and of their ability to maintain a safe and protected environment (Mandell et al, 1989). Facilitators helped members feel connected to the group by pointing out commonalties. Facilitators had an understanding of possible dynamics that could arise during this first stage. Areas monitored were communication and interaction patterns, cohesion, group culture and social control mechanisms such as norms, roles and status (Rivas & Toseland, 1998).

In this first session, participants demonstrated feelings of ambivalence, excitement or anxiety, or all three. Often members appeared hesitant and uncertain about the group experience. Approach-avoidant conflicts appeared as the session progressed. Children advanced, trying to get to know others, only to recede when the interaction seemed too intimate (Rivas & Toseland, 1998). Additionally, the children seemed understandably cautious about what type and how much information they were prepared to reveal. The children had a clearer understanding of what the group expected from them through the development of group norms. Participants had been made aware of the role of volunteers in the group and reacted to them much the same as to facilitators.

In the second session, the group members addressed the theme of "Addictions as a Feelings Disease". Again, arrival times were staggered and presented the facilitators a challenge for organization. This resulted in the need to reiterate learning goals to the latecomers. Some children volunteered to share what they recalled from the previous session. As in the first meeting, the workers established the purpose of the group for the participants. This was done with the help of the 'neighborhood board', to assist the

children in being centered and keeping focused (Mandell, et al., 1989). The symbol for this session was a mask, symbolic of covering up feelings. The group participants continued to form relationships and build trust with each other.

The objectives of this session were to help the children to learn that everyone has feelings and has ways to accept and express them, as well as constructive ways to understand and handle their feelings. These objectives were achieved. In this session the members tried to establish connections with each other. BB. entered the room and discussed her recent home visit with the other members. She included details about her family members and the means by which she attended (bus). Facilitators continued to do the majority of the talking, assuming the role of educator and ensuring that no one was left out of the group process. The group was challenging in that several members had to be reoriented to the expectations around talking and taking turns doing so. With little effort, the facilitators led interaction and discussion amongst the membership. The topic of addictions as a feeling disease appeared to heighten the anxiety levels for many of the children. Some responded to this by becoming disruptive in their behaviors, interrupting and making contributions not related to the topic, while others withdrew. Many reminders were made by facilitators to keep the interactions on track. Facilitators also prompted those who were unresponsive.

It was noted that most of the children took personal risks, prompted or otherwise, and shared their personal thoughts and feeling about living with an addicted family member. One of the children related in detail having to care for younger siblings, and the stress this caused for him. BB. concurred with this feeling and then related herding her siblings into a closet in order to be safe during drinking parties. A. and B. conversed

about the loyalty conflicts arising from having to seek shelter elsewhere during these times and how hard it was to make the decision to leave even temporarily and what the emotional retaliation would be when the caregiver sobered up. Most of the children were quite well versed in the effects of alcohol and marijuana on people, but less so respecting hard street drugs. A. was able to educate the others about street drugs. From the dialogues emerging it was obvious that most of the participants felt relatively comfortable and were prepared to talk about personal and private thoughts and feeling, despite the anxiety that comes with taking such risks.

The majority of the agenda was accomplished, although because of the staggered arrivals times, some of the introductory activities were out of sequence from the plan. Facilitators considered requesting additional time; however most of the participants had prearranged transportation that could not accommodate this. The activities in this session could easily have formed two sessions and encompassed an additional group meeting. The orientation stage could always use more emphasis (Rivas & Toseland, 1998).

The facilitators acknowledged the need to consider a proactive stance on arrival times for the children. The flow of topics and routine was somewhat compromised, as workers concentrated on completing activities that helped integrate the theme of the session. The facilitators recognized the need for the children to be actively involved in learning, and they did appear to respond better to hands on learning experience as opposed to a lecture format. In fact, half way through the session, one of the more verbal members requested a break from the format. The facilitator initiated a 5-minute game of "tag" outside the facility. All the children participated in this and that seemed to settle their anxiety and energy level considerably.

The activities initiated to facilitate the objectives for this session included making masks with contrasting feelings on either side. Upon completion a discussion was initiated about the symbolism represented and the ramifications of not wearing a mask. This led into an introduction to the "three C's", (cause/control/cure, none of which the child is responsible for in addicted people). The members were given a pile of multicolored C's and created posters/collages outlining their understanding of the "three C's". The finished projects were then placed together on a larger poster and used as a visual aid for the remaining sessions. The finale was the popping of balloons after each member was encouraged to envision a frustrating or scary situation relating to substance abuse, with the balloon being symbolic of releasing the feelings generated.

In this session, facilitators' focus was on assisting the participants in joining together and increasing their reliance on each other. The children were encouraged to interact in positive ways that respected the norms and values of mutual aid group work (Glassman & Kates, 1990). Facilitators observed the emerging interaction patterns and began identifying group roles. For example, E.'s clear leadership role which was countered with F.F.'s almost complete withdrawal. These two members posed a challenge as facilitators attempted to be inclusive of all members, ensuring that no participant was left out of the group bonding process (Mandell et al, 1989). Practitioners observed continued avoidance/intimacy conflict for some members, such as B. and B.B., whose conflict could easily have spread to the other members without close monitoring. Participants were invited to express and identify their feelings. Facilitators helped the group examine the process in which they were involved (Glassman & Kates, 1990).

Group Issues

Some participants continued to feel anxious and uncertain about attending the group. As groups continue to interact, alliances or dyads are likely to form (Rivas & Toseland, 1998). Some children may feel left out. Children may react to this by vying for attention or withdrawing from the group. In this regard, F.F. remained verbally uninvolved with the group, though he completed the activities with the others. D. was drawn out by facilitator, addressing questions directed to her, but otherwise remained withdrawn. It was observed that participants may still experience ambivalence about the group.

At times, the membership resisted the concepts. After more emphasis was placed on feeling safe and building trust within the group context, there was a reintroduction of the noted material (Mandell et al, 1989). Uncomfortable material for children resulted in disruptive behavior within the group. An example was seen in B. and B.B's arriving late and declining to participate in the group discussion until their behavior became so disruptive that it became the topic of discussion. At that point, they responded to questions about their behaviors, falling silent again when the discussion was redirected, allowing the session to resume.

The theme for the third session was "Families and Addictions", and the primary objectives were to have the participants develop an awareness of how they feel about their families and to learn that other children are in the same circumstances as they are. This theme was facilitated with the use of a neighborhood board symbol. The symbol used was a teddy bear leaning against a bottle of alcohol. Another goal of this session was to facilitate an understanding that their families are similar in some ways and

different in others. The members were given the opportunity to practice expressing feelings and offering feedback to each other.

The members appeared to have attained these objectives, achieving a great deal more interaction and cohesiveness as a group. With the exception of FF., members were offering thoughts and feedback to each other intermittently, between facilitators' redirection and focusing on the tasks at hand. The group was so energized and stormy that BB initiated another "tag break". This appeared to be much needed and properly utilized with no difficulty regrouping following ten minutes of play. The group, with the exception of the one member, openly joked with each other, and alternated alignments and leadership roles. At this point, the group membership had formed preliminary relationships. Personal connections were made between members. By then the members were familiar with group structure and the concept of the group was becoming clearer. Some children looked forward to the coming group sessions. When asked if they liked group, participants responded that "group is fun-what are we doing today". Facilitators found that children began to use check in time to share personal feelings about events during the week. This indicated that members were feelings more comfortable and willing to share with each other.

Starting off, the membership generated a list of "family rules", both spoken and unspoken. There seemed to be a lack of interest in completing the group activities, which were the "Bicycle game" and the "Bubblegum Family". This appeared to be related to the difficulty that the participants where having focusing together on one issue at a time for more than a few minutes. Due to a lack of verbal participation in the activities, the activities were completed well within the allotted time frame. However, during high

energy focusing, the group as a whole took more initiative to ask questions and to control their own learning. The storming seemed to be a challenge to the leadership and there were resulting power struggle issues. Many of the participants began talking over the facilitator's directives and the rules and expectations. The rules and expectations needed to be restated and then modeled.

For follow up in the next session, the rules and expectations were reviewed in an effort to proactively facilitate smoother group process where all would participate. The group process as a whole remained respectful and supportive, although an undercurrent of anxiety was felt. When reminded of the group norms, the membership adhered to them. Additionally, the children helped each other out in doing so. Interestingly enough, the group as a whole seemed to need no clarification that others had families stuck like theirs, or that they were not alone.

It was anticipated that by the third or fourth group session the group would have entered the middle stage of development (Glassman & Kates, 1990; Rivas & Toseland, 1998). Facilitators and members worked together on more difficult themes. It was understood that the group had entered into the 'storming' stage. Facilitators watched for conflict and power issues within the group especially apparent between B. and B.B. and increasingly so with D. Resolution of conflicts was achieved by facilitator redirection and/or dialogue before the group continued to progress (Glassman & Kates, 1990).

At this stage of the group, the facilitators anticipated that the group members would challenge the facilitator's authority role. Certainly, much more chaotic interaction among all members excepting F.F. supported this theory. The facilitators expected themselves to possibly react to the conflict with feelings of inadequacy (Glassman &

Kates, 1990). The facilitators helped participants explore their feelings and respected their right to do so. Self- disclosure and sharing of feelings is believed to help members with this process (Glassman & Kates, 1990). Facilitators clarified the group process for the members. Facilitators noted the present interactions for the group and facilitated group communication (Rivas & Toseland, 1998). Facilitators attempted to avoid interpreting or answering for children.

As expected, participant's interactions were chaotic and distracting and there was some attempt to avoid the group 'work' of exploring themes, as E., D. and B. all competed for a leadership role. D. and E. made disclosures about personal histories. It was critical to validate the child's experience and ensure his/her safety (Mandell et al, 1989). B. and B.B. appeared overwhelmed by their feelings, and disengaged physically from the group. Other participants requested multiple washroom breaks which resulted in disruption of the group meeting (Toseland and Rivas, 1998).

At the fourth session the group was more settled in the working stage and came together more quickly to begin the session which focused its theme on "Families and Addictions-Part Two". Several children commented that they had received the "3 C's" in the mail and recalled amongst themselves what the C's stood for. Facilitators had modified the follow up letter originally intended to bridge the gap between sessions. Rather than using a written format, each contained strictly visual reminders of material covered in the previous session. This achieved the same purpose without leaving the children feeling like they were doing "homework", which had been posed by them as an issue from the previous week. Participants responded more positively and energetically to

this variation. The neighborhood board symbol for this meeting was a small collage of various super heroes, indicating power.

Initially, the group constructed a "telephone book" of names and numbers they could call if help was needed. The majority of the agenda was covered, although the group was unable to complete the problem solving questions. The children ate popcorn and watched the movie, "Twee, Twiddle and Huff", (Johnson Institute, 1989), a fable about Woolums (mythical people) specifically, three Woolum children and their parents who are addicted to dancing with a genie. The film presented a non-threatening allegory that offers hope and understanding to young children living with caregivers affected by addiction. Following the viewing a discussion was facilitated in which the majority of the participants seemed to be able to comprehend the analogies. They were supportive and respectful of each other and members made statements about their own experiences. At times, there was some talking over each other and facilitators, and this required some reminding of the rules and expectations. Also, the group requested to see the one way viewing room, which was accommodated. All group members participated openly, with the exception of FF. During the completion of the "Bicycle Game", the group seemed disconnected and chaotic. However, in the discussions that followed they appeared to have made more of a connection than anticipated. BB. requested a "tag break", which was facilitated and in which all the children, with the exception of FF., participated and seemed to derive benefit from. Upon completion of the break, the children presented as ready to concentrate on the final material to be covered.

All of the participants talked about their current placements away from their parents at one point, and it being a safer place than home. While constructing the phone

books, all of the children identified that these were people that they could call anytime, even if they went to their birth homes and things got crazy again. For some of the participants, there was not enough clarity on concepts, although the concentration as a group was good. Some of this was likely related to the varied levels of functioning amongst the membership. This made getting all children at the same place a challenge.

At this point it was anticipated that the group had reached the level where conflicts are resolved (Rivas & Toseland, 1998), and were now ready to move to the 'work' stage of group. The membership managed this adequately; with exception of B.B. who often began referring to unrelated topics and trying to engage B. in verbal arguments separate from the group process. As the stages progressed, the intensity of the chosen theme progressed. This increased the potential for the children to feel discomfort and to be challenged. The group roles and dynamics were monitored to ensure all participants were involved in the group process (Glassman & Kates, 1990). Moving through this session successfully attained the objectives of increasing communication between members, dispelling myths about addictions and integrating a better understanding of a child's power within an addicted family. Also included was an exploration of using different options as power in the re-authoring of the participants' experiences.

At this stage of the group, facilitators assumed the role of director, observer and facilitator. Facilitators supported the group members in exploring the various roles and facilitated a sharing of these roles. Facilitators began the process of further involving members in productive work (Glassman & Kates, 1990). Most commonly, this took the form of redirection. Increasingly, facilitators began tying together individual comments from previous sessions with current themes and discussions of experiences.

It was assumed that group conflicts at this stage of group development would be resolved and power differences equalized. Clients began to relay positive feeling about the group experience and started working on issues. Seen as the productive time, the group joined together and worked hard to accomplish the purpose of the group (Glassman & Kates, 1990). Concerns to monitor were: (a) clients feeling embarrassed about discussing sensitive material, and (b) children needing to be encouraged to express themselves openly.

Session five's theme of Coping achieved the goals including the goal of problem solving and effective coping techniques and activities. This occurred despite the group presenting as slow and disinterested. The symbol for the neighborhood board integrating this theme was a question mark. One of the members did not complete any of the activities but did contribute verbally. Barriers and issues that arose included BB. constantly asking about a "tag break" and D. about treats to the point of disruption. The group in general seemed to be experiencing boredom and low energy. At one point, BB. and B. saw a staff member they knew and ran out of the room to greet her, although they returned soon after.

Session five continued with similar behaviors as those observed in the previous group session. The culture of the group became more pronounced as D. and B. became more blatant in their attempts to control the agenda, ignoring facilitators, despite repeated redirection and encouragement to rejoin the group topics/activities. Regardless of this, facilitators noticed that members were more expressive of their feelings (those participating). The facilitators worked particularly hard to keep the group focused. Volunteers and facilitators focused more directly on nonparticipating children in order to

draw them in and help them engage with the other participants. The children for the most part presented as being quite comfortable with each other, and made supportive comments in response to personal anecdotes. Several actively participated in defining positive and negative coping and how addictions make problems more difficult to cope with. Clearly this session was well into the working stage, and work they did. BB. asked for help with reading and was quickly assisted by B.. BB. was comfortable asking for this without any indication that she was ashamed or sensitive even though she was clearly struggling with material.

The children easily completed the problem cards, dividing into teams of two to read them and generate coping ideas for them. All the members responded well to the guest speaker, with several openly asking questions about her experiences and her comments. All did so using the expected guidelines. Several of the participants began reading aloud from the written quotes that the facilitator had taped to the table top which outlined the previous week's themes and the current theme. The facilitators used the introduction and discussion with the speaker to transition into a discussion about the different degrees of recovery, and that it is an ongoing process, which may or may not be complete. It was reinforced that regardless of the caregiver's state of recovery, children need to get what they need to grow up and be safe.

Although somewhat stormy, most of the group members continued to openly speak of their own experiences. It was observed that some of the members tried to use the group forum to understand their own experiences. Additionally, it was observed the children were cohesive and supportive of each other. They began to take charge of their own learning, asking questions to gain understanding, successfully achieving the

objectives of discussing problems with addicted families and learning alternative and healthy coping.

In reflection, one thing that the facilitators should have done differently would have been to have a physical activity before the speaker portion of the session. Perhaps this diversion would have given the members a chance to burn off physical energy and made for a quicker, more energetic start.

Regarding issues at this step of the group development, facilitators continued to educate the group. Facilitators encouraged members to maintain involvement and make decisions about group dynamics. Facilitators suggested that group members try different roles and ways of interacting within the group setting (Garvin, 1997; Rivas & Toseland, 1998). Johnson & Johnson (1997) remind facilitators that the group as a whole becomes more independent of the facilitators at this time. The participants could be observed taking charge of their own learning experience.

During the middle stage of this group, the participants challenged the information/ learning offered by the facilitators. At this phase, the participants sometimes refused to listen to the instructions of the facilitators and even ignored the facilitators altogether. The group became more cooperative as facilitators observed more 'we' and less 'me'. The children started to direct and motivate each other's learning. These interactions sometimes had a negative outcome, leading the group off topic (Johnson & Johnson, 1997).

At session six, the theme of "Change" for this session achieved goals including self-empowerment, clarifying what you can change and cannot change and differentiating between the two, as well as identifying who can help you achieve your goals. The group

membership remained supportive of each other and working together, although there was some storming. On the whole, the mood of the group seemed subdued but focused. FF. particularly was working harder than usual and BB. and B. had some moments of "sibling rivalry". Not present at this session was D., apparently related to a mix up in communication between the caregivers and the drivers due to the Remembrance Day holiday.

Issues and barriers in this session included the alignment and sibling rivalry B. and B.B., which elevated into neither girl participating with any commitment. The girls talked over other group members and facilitators at times. In hindsight, it might be a good idea to have physically rearranged the girls, either by changing their seating or by assigning direct tasks.

The activities completed to achieve the objectives included the neighborhood board, the "Wheel of Misfortune", and the development of lists of what you can and can not change and a game of tag. The alternative activity, the "garbage bag game", was not utilized due to time constraints. Participants began the first stage of designing window clings, painting cellophane pieces with paints which upon drying peel off and can be placed on windows as decoration. The designs incorporated symbols of the themes from previous sessions. The collage made during the first session was briefly revisited, which depicted what someone who is "stuck" might look like. Discussion was easily generated. It was observed that members now understood that they would not have to look so hard in the magazines for addicted people because anyone could be an alcoholic.

Session six continued at the working stage of development. The group had become strongly cohesive and connected. Together, the participants were working

towards the completion of tasks that would actualize the purpose of the group (Toseland and Rivas, 1998). The group membership was challenged to work on achieving their initial group goals. Facilitators challenged the participants to stay on task with the learning objectives.

Facilitators anticipated that the members might feel discomfort when discussing the increasingly sensitive nature of the topics. Facilitators prepared themselves for the discomfort and modeled a forthright manner in exploring the topic at hand. Facilitators monitored and observed behaviors, processed dynamics and directed interaction so that the children were helped, not hindered, by the deeper examination of the themes (Mandell, et al, 1989).

Children may feel shame or guilt about their family member's 'illnesses or they may assume responsibility and withdraw at this stage. This seems to bear out. Some children in particular became anxious and uncomfortable about the intense nature of the theme and acted out their emotion by engaging in disruptive behavior. Children experiencing difficulty talking about this theme interrupted the group process, distracting the facilitators and participants from group goals. These members required encouragement to stay focused.

With the arrival of session seven, it was stressed that the time allotted for the group was quickly coming to an end. This period concentrated on the completion of group goals and purpose. Children were given a chance to practice their learning and to translate it to other situations (Cormier & Cormier, 1985; Garvin, 1997; Rivas & Toseland, 1998). At this point in the group process children were prepared for the upcoming termination of the group (Dimock, 1970).

The objectives for this session, as outlined, included practicing the concepts and skills learned by translating them into real situations; to practice problem solving skills, and to help the children recognize that while they cannot chose what happens to them, they can chose how they respond to the incident. Particularly, they were taught that you can learn new ways to respond and that they do not have to be the same ways used in the past. All of these objectives were accomplished. These objectives were initiated by the use of the symbol of a child standing at a crossroads on the neighborhood board.

Barriers that arose in this group session pertained to two of the members being particularly unfocussed, to the point that they left the table in the middle of the discussions and searched the room for reading material. There was also some bickering between B. and BB. Both of these distractions were easily remedied with physical and verbal redirection. As a whole, once the barriers were reconfigured, the group was working hard but also withdrawing and disengaging to some extent. This may have been a response to the reminder that there would be one more session before Kid's Power came to a close.

Within the group, the dynamics also continued to change. BB. and D. somewhat isolated themselves from the greater group, by leaving the table altogether. For D. this was a most usual move. The remaining participants interacted with each other, although FF. not overtly so, he tended to be more responsive when others interacted with him.

Activities for this session, which helped accomplish the goals and integrate the theme, included finishing the window clings started in the previous session, the neighborhood board, and although it had not been planned, another round of "The Wheel

of Misfortune". The participants requested a repeat of this activity having enjoyed it immensely the first time it was utilized.

The facilitators recognized the various response participants had to the termination process. The facilitators invited discussion about these thoughts and feelings and continued to direct, observe and cultivate interactions and dynamics. Facilitators dealt with ambivalence towards the production phase (Glassman & Kates, 1990).

Facilitators had some ambivalence about the closure of the group. For this writer there was a sense of camaraderie only fleetingly felt before the final session, which made directing the disengagement process challenging. Possibly this relates to unresolved loss issues, exhibited in a tendency to hurry the good-bye process and difficulty addressing closure issues (Rivas & Toseland, 1998). It was important not to rush through the good bye process or to only focus on the celebration aspect. Sometimes facilitators felt they needed to keep the group together past the allotted time, falling prey to some of the participant's reluctance to end the group. The facilitators focused on preplanning and preparing the good bye session, reviewing what the outline of the final session would be. The children were asked to consider their future events, such as how they felt they could use the knowledge from the group and what they needed to do to achieve success in their lives. The facilitators ensured closure on all situations for all members prior to ending. Facilitators encouraged the participants in the exploration of feelings of termination in relation to the past and a readiness to end was reinforced.

At this stage of the group, it was anticipated that members would start missing sessions (Rivas & Toseland, 1998). Absenteeism can be attributed to a member's desire to avoid the working phase of the group. This was not a significant issue for this group,

though there were some incidents related to miscommunications. Other children had feelings about the missing members. Evidenced by comments made by the membership, absent members were missed by regular members (Rivas & Toseland, 1998).

Participants had a variety of feelings about termination. Termination created different reactions in the group participants. B. and B.B. regressed in behavior, whining and giggling and denied the end of group was upon them by insisting they would be back for weeks to come. Some, such as E. and F.F. responded with flight tactics, and returned to avoidance or looked forward to the end in a positive manner (Corey & Corey, 1997; Rivas & Toseland, 1998). At this time, the children needed to review their successes and plan for the future.

As this was the second to last session, the facilitators began the process of review and summarization of the learning. The group focus began moving back to an individual focus. The children returned to more individualized activities and reviews (Rivas & Toseland, 1998). For example, rather than discussing group experiences and comments the children were asked what they would do with this group experience pertaining to them directly.

Session eight was the last session. It was devoted to celebrate the accomplishments of the children. The final theme was of "Self Care and Good Bye Celebration". The group gathered together for the last time. At this good bye event, the check in and check out process continued. The first portion of the session focused on facilitators reviewing the group goals and objectives. The group events and learning were reviewed. Emphasis was placed on reviewing group purpose, group accomplishments, and the future and healthy closure (Rivas & Toseland, 1998). Each

child was given a folder containing their completed activities from each session, a certificate of completion and some visual reminders of what she/he had learned in the group process. This provided an opportunity to reflect on the group process. Children completed the regular simpler scales (Appendix E-G), along with the standardized questionnaire (Appendix J) and a brief and simple learning scale (Appendix J). The remainder of the time was spent building gingerbread houses, and reviewing self care. The members shared in the celebration by building an "addiction free" gingerbread home and eating pizza.

It was important that the facilitators were aware of the members' reaction to group closure. Flight/avoidance, anger, denial, regressive behavior and/or a healthy anticipation may all be expected responses of the participants (Rivas & Toseland, 1998). The majority of these appeared to have shown themselves in the previous session, though an awareness of these varied reactions to a termination process assisted group facilitators to facilitate and/or model discussions or role-plays that addressed client concerns about the group ending.

Thursday Sessions

The participants of this second group were markedly different from those in the first group in several ways. While all members sat separately from each other as expected in the beginning, three of the six engaged easily in the topics and activities, almost from the start. As the children completed their nametags, all were observed to be more relaxed. Approximately 1 minute into the first session, G. arrived. G. immediately joined the group at the table and settled in with little problem. The children, with minimal prompting from this facilitator, debriefed this member on the purpose of the group, the

rules and the behavioral expectations. Possibly because she was 'the little one' the other participants felt 'older' and instinctively protective of G.

Group participants accomplished most of the agenda for the first session, incorporating the theme of "Getting to Know Each Other". These objectives included defining acceptable group behavior and guidelines for monitoring behavior and keeping confidences. Members participated in getting to know each other and demonstrated feeling more comfortable; this was facilitated through discussion about commonality of experiences and the effects of substance abuse on the body. Activities facilitating achievement of the goals included nametag decoration and discussion and a collage of magazine pictures the participants felt were of people who were addicted; this integrated the session theme.

In this group, the sequence of activities and organization was better than in the Tuesday session. Following the completion of the nametags, introductions took place, with an offering by each child of one thing about that child. All of the participants engaged in this task with minimal prompting. By the end of the exercise, members were offering their own insights, and in fact things got a bit off track with some of the children trying to offer thoughts all at once. They were easily reminded of the expectations and the reasons for them, and this successfully redirected their energy.

A primary idea about why this group seemed to be different from the Tuesday group emerged. While this group was larger and had more sibling dyads, more prominently, it seems likely that facilitators had a "practice run" with the Tuesday sessions making the Thursday sessions familiar and easier to anticipate. The benefit of the 'practice runs" was easily passed on to the Thursday group in the form of facilitators

being better prepared and more insightful into possible problems and solutions. What activities worked and appealed to the groups were different but the capacity to manage them and offer alternatives integrated into the programming scheduled was more adept.

G. was noticeably more delayed than the other group members in terms of her global abilities. For example, while most of the participants were able to make connections between semi abstract concepts and the basic activities at hand, this child seemed to be completely disconnected from this at even the most basic level. In spite of this presentation, G. quite happily completed the tasks asked of her and joined the group conversations, although her comments were at times detached and simplistic. A second child, EE. initially presented this way, but with some assistance from the other members was able to make the leap in reasoning. Neither of these two participants was able to read or write beyond a rudimentary level.

This group also included two siblings who had originally been booked into the first group. They seemed to fit quite well in this set. Every attempt was made to have siblings participate in separate groups. Logistics dictated this was not possible in this case. Interestingly, this did not pose a dramatic problem in the first session. While the two sisters definitely aligned with each other initially, one of the girls was able to separate and engage independently in the group process. The remaining sister continued her efforts to engage her sister apart from the remaining group members, but for the most part was not successful. This disallowed a potentially disruptive dynamic from erupting. The remaining sister eventually abandoned her efforts and began to reluctantly interact with the membership. She was not disrespectful and was easily redirected.

As in the first group, this group accomplished all of the items on the agenda for the initial session, including activities that integrated the session themes. Again, the range of levels and abilities was noted, and at this point appeared to be a minor disruption in the group dynamics.

In the second session, two of the participants missing from the first session appeared. These members had been scheduled to attend the Tuesday group rather than the Thursday group. One of the new members settled in quite amiably while the second child did not. He had in fact been present for the Tuesday session but refused to enter the room. This time around, he was able to enter the room; however his behavior and verbal interactions with the other member present was so threatening and anxiety provoking to the other children that the decision was made to have him leave the session with his caregiver. Clearly he was not ready for the group work and was not comfortable in a group peer environment. His caregiver later reported during a follow up phone call that once outside of the meeting room he related that he felt scared and overwhelmed by so many other people.

The remaining members reintroduced themselves to the addition, and several of them volunteered to review the previous week's material, leading into this week's theme of "Addictions-a Feelings Disease". Time was required for debriefing and regrouping with regards to a member who decided not to participate in the session. This resulted in a rushed check-in and a lack of time to properly process all of the housekeeping issues. As in the first meeting, facilitators established the purpose of the group for the participants, which helped to centre and focus the group (Mandel, et al., 1989). The group development remained in the orientation stage due to the introduction of the new

members (Rivas & Toseland, 1998). Members continued to form relationships and build trust with each other, with the exception of the new member who remained in a more observant role expected for her first session. The objectives of this session were to help the children to learn that everyone has feelings and to teach them ways to accept and express them, as well as understand and handle their feelings constructively. This objective was achieved.

In this session, all the group members, with the exception of the new child, were noticeably more verbal but also storming and displaying high levels of energy. During interactions and discussion of the topics, the group members became noticeably agitated and easily distracted in their comments and interactions with each other. Although the children were easily redirected, the need for redirection was constant and exhausting for the facilitators. It was unclear whether this distractibility was related to losing a group member, the topics or the group dynamics and stage of group development. The topic of families and what it is like to live in an addicted family seemed to (as in the first group) heighten anxiety levels for many of the children. With much redirection, most of the participants were able to relate their experiences and feelings about living with addiction.

G. frequently asked for clarification about issues or what was depicted in some of the visual aids throughout the room. The remaining members were able to utilize this as an opportunity to give their definitions of the question and then quantify the statement with an example from their own experience. The children were well versed in alternative means to manage behaviors and feelings and had examples of both positive and negative ways to do this.

The activities initiated to facilitate the objectives for this session included making masks with contrasting feelings on either side. Upon completion, a discussion was initiated about the represented symbolism and the ramifications of not wearing a mask. This led into an introduction to a discussion of the "three C's", (cause/control/cure, none of which the child is responsible for in addicted people). The members were given a pile of multicolored C's and created poster/ collages outlining their understanding of them. The finished projects were then placed together on a larger poster and used as a visual aid for the remaining sessions.

The theme for session three was "Families and Addictions", and the primary objectives for participants were to develop an awareness of how they feel about their families and to emphasize that other children are in the same circumstances. Further, there was an objective to facilitate an understanding that COAs and their families are similar in some ways and different in others. These objectives were attempted within a context of encouraging the members to practice expressing their feelings and offering feedback to each other.

The objectives were achieved, as witnessed in the comments and interactive statements made by the participants. This second group was much more organized as a group and was better able to concentrate on the tasks than the first group. One member, C., was absent due to illness. This same child had also missed the first session. Activities were completed in the time frame allotted and the discussions that followed were especially productive.

The group appeared to be gaining trust amongst its members, illustrated by the increasing amounts of self-disclosure and the respectful and supportive responses of the

COAs. The participants interacted openly with each other, followed directives and respected the rules of the group. The exception was F., who was quiet and withdrawn from the group.

Similarities between their personal situations were identified; several members related their experiences with the addicted person in their family. G., the youngest member of the group, related witnessing her mother being stabbed by her father, and the feelings this caused her, as well as the action she took to keep herself and her siblings safe. The remaining group members offered support to her strength in dealing with this and the fear she felt. Several others, including A. and AA. (siblings) related how they often had to leave the home when their auntie started drinking, and where they would go and when (at night) which was scary for them. This facilitated DD. relating similar experiences with her mother and grandma, that they "were crazy just like my family when they drink". Almost all the membership spoke of similar experience with addictions and domestic violence. C. was the sole member that related violence was not always a factor in her home because "my mom slept all the time when she was using (crack)". Some discussion ensued related to differences between addiction to alcohol and crack. There were no obvious gender divisions or subgroups, with the exception of the siblings. Almost all the members identified alcohol as the primary problem for their family, involving multiple adults in care giving roles. Interestingly, AA. was very clear in her responses that she in no way felt this was her problem or fault. When completing the bubblegum game, she openly stated she would not be participating in the way the others were because "I'm not getting stuck in someone else's problem-I'm going to stay away and make sure I'm okay". Her spontaneous remarks and strong affect provided an ideal

summary to the purpose of the game. This permitted a connection between past responses and related to "walking away" from their home to foster care or to alternative caregivers. This session was particularly clear in its understanding for the members, and did not appear to need clarification other than the initial review at the start of the next session.

The activity facilitating this learning was the "Bubble Gum Game", which utilized a pink blob of stuffed fabric as the analogy for addiction in a person and the domino effect of children getting caught up in something that is not their doing. This illustrated for the group how they instinctively respond to the situation and what they can do differently to make things easier for themselves. Facilitators opted to leave out the alternative exercise, "Bicycle Game" which seemed slightly too complex for the majority of the Tuesday group.

Aside from G. arriving late, all members were present and on time for session four to debrief and being to focus on the session's theme of "Families and Addictions-Part Two". Arrival times, by this time, had become standardized. The group was quite animated and worked hard at this stage, but clearly struggled emotionally with the topics at hand. When asked, members offered to review previous group themes missed by C, now present for the first time. All did so in their own words, indicating their level of comprehension of concepts. All commented on the mail out. Their understanding was reviewed and connected to previous themes. Following this, the facilitators and member's demonstrated the "Bubble Gum" idea.

There was a brief discussion respecting choices in how to handle an addiction and a person who is addicted, which led into the theme of self-care and a discussion of how the only one you can control is yourself. One of the ways is by not getting "stuck", or

caught up in another person's addiction. The group first designed plastic window clings, which included symbols of material previously covered. They then settled in to watch a film and eat popcorn; a dialogue followed this. Group members actively participated in the dialogue. They shared insights about "dancing with the genie in the bottle", a metaphor presented in the film, and whose responsibility it is to take it out or put it back. The COAs also talked about differences in degrees of recovery. C., A. and AA. all volunteered comments on the degree to which their family member had recovered. C. commented on not wanting to tell anyone about her parents' drinking but feeling conflicted because she still had to keep safe. She expressed that she knew her mother would be mad but was still making the decision to go to the neighbor's place when she needed to be safe.

Everyone commented on the parallels between the movie and the purpose of the group. They also compared the facilitator's role with the teacher's role in the movie. The children frequently talked over each other and needed a lot of reminding not to so. Due to time constraints, the group was not able to complete the "telephone book" activity. They offered verbal examples of who is safe and can be called upon if they felt unsafe at home, and they identified safe places. They demonstrated an understanding for the need for a safety plan, in light of recovery being ongoing.

Coping was session five's theme and the goals were for effective coping and problem solving. Issues noted included C. arriving late, which threw the group off and required backtracking to have her cover the review items. Both EE. and F. seemed to align themselves and became disruptive while engaging in a separate and loud unrelated conversation. Facilitators dealt with this by promoting the development of the group

norms, changing seating and pointing out the need to respect others (Toseland and Rivas, 1998).

Group process and the apparent stage involved some obvious storming, but for the most part the group worked well together. Members were open with their comments and supportive of each other. In particular A. and G. when matched together made an excellent compliment even though they represented developmental extremes within the membership. This was recognized when the group was separated into groups of two to complete the problem solving exercises. There was much self disclosure overall, and most of the members utilized the language of the past session, i.e.; "stuck". They also eagerly reenacted explanations of this language through such examples as the Bubble Gum Game. Several of the children made artwork that incorporated themes past and present. DD. made a "book" on which each page had an illustration of the past themes and language.

Activities included problem cards, the neighborhood board and thematic words on the tabletop and a guest speaker. The Bubble Gum game was reenacted to bring the guest speaker into the learned material. In hindsight, facilitators should both be more actively moving in the group, and perhaps even splitting the group into two, allowing one to "play" while the other interacted with the speaker. It might be better if the sessions had been structured differently. The interactions with the speaker could have been more casual. This could have included a longer period of time for more specific comments to ensure that the exact issues were captured, though all indicators were that the concepts had been integrated.

Session six was successful in achieving the goals and objectives of integrating the theme of "Changes". The goals included differentiating between what one can and cannot change; making changes in themselves and identifying who can help them accomplish the changes. Some of the noted barriers were that both EE. and F. seemed to be closely aligned and going off on tangents that pulled in the other children (Toseland and Rivas, 1998). This served to get the whole group off track at times and constant redirection was the order of the day. C. was talking over everyone, members and facilitators alike. For the most part none of the children were raising their hands, which added to the chaos. In the future a review of the rules would be helpful with an emphasis on these particular dynamics.

The group was definitely at a working stage and although chaotic it was cohesive. The members were obviously comfortable with each other, supportive of each other and listening well when on track.

AA. and C. seemed to align more this session, with A. standing more independently, and participating more. EE. and F. were very separate from the group and off on their own, although they remained closely aligned with each other. The group's comfort level with each other was evident in their self-disclosures and supportive responses. One member, EE. continued in his usual pattern of offering more when prompted but participating little. For the majority, the session dynamics were spontaneous, with lots of joking amongst the group and several of the more outgoing members offering to clarify some of the concepts and discussion for G., the youngest member of the group.

The activities utilized in this session included the neighborhood board. The symbol used was a question mark, to symbolize the theme of changes. The group began the initial work on the window clings, which required the incorporation of a theme from any of the previous sessions. The "Wheel of Misfortune" was the next activity followed by the listing of what can and cannot be changed. This seemed to get the group more cohesive and focused. In addition, this session encompassed a fairly lengthy discussion regarding good and bad touches, a definition of them and what to do if faced with such a problem. This discussion was initiated by the group themselves in response to comments made by a member about her own experiences.

Session seven was similar to the Tuesday session seven. The goals and objectives were the same and were achieved under the guidance of the "Choices" theme. Some of the barriers presented during this session included G. and EE. being more scattered than usual, repeatedly leaving the group or going off on conversational tangents. This required constant redirection, prompting, and reminders of the rules. When these were provided the children did get back into the group and participate. However, their ability to do so for any length of time was limited.

The group dynamics were interesting in this session for this group, in that three members were missing, leaving only four present. Each of the four worked independently and interacted well verbally and supportively. There was a noticeably calmer and quieter demeanor over all. There was a lot less aligning in the membership, and one member DD. commented that she "didn't miss the others because they are so loud".

The activities included in this session were the neighborhood board, finishing the window clings, and a collage incorporating all the materials covered to date from posters

made with each of the projects completed by the group. This collage was not done with the Tuesday Group but was improvised at the spur of the moment and worked well for this meeting. DD. had missed the first part of the window clings exercise, thus was provided with the opportunity to begin hers, and to take a set home to her sister D., to be completed next session. Again, the final reminder was given that Kid's Power would be completed in the next session.

The last session was used to celebrate the accomplishments of the children in a formalized manner. The group gathered together for the last time. At this good bye event, the check in and check out process continued. The first portion of the session focused on the facilitators reviewing and repeating the group goals and objectives. The group events and learning were reviewed. Emphasis was placed on reviewing the group purpose, the group accomplishments, the future and healthy closure (Rivas & Toseland, 1998). Each child was given a folder containing their completed activities from each session, a certificate of completion and some visual reminders of what she/he had learned in the group process. This provided an opportunity to reflect on the group process. Children completed the regular simpler scales, along with the standardized questionnaire and a brief and simple learning scale. The remainder of the time was spent building gingerbread houses, and reviewing self-care. The purpose of the building of the addiction free gingerbread home and the eating of pizza was for all members to share in the celebration.

The groups went through the apparent stages of development, reflecting a beginning, middle and end process. The different phases of group development portrayed a variety of group dynamics such as power and control, leadership, problem solving and

establishment of group culture. Observed in this group were themes of mutual support, mutual aid and empowerment among the facilitators and participants. The children formed a unit together, and offered each other support, hope and ways of healing. Together these groups joined as individuals and formed a group that worked together to accomplish the group purpose (Rivas and Toseland, 1998). Members appeared to successfully address the original purpose of the group at a beginning level. Neither group advanced any more in their development as a group than the other did. Rather, each progressed at their own pace, ultimately reaching the end in unison.

In the initial group sessions it was clear that all participants needed an opportunity to process resolution of their own experiences related to a caregiver's addiction before they could move on to addressing the original group purpose. Group time that was planned was consumed by the need to address secondary victimization and locus of control issues related to the addictions. Facilitators really need to be prepared to deal with an array of very powerful, and for the children, very scary issues. The victimization issues included all types of traumatic experiences at a number of levels. These issues included family violence, death, physical abuse, sexual abuse and neglect. Once the children had the chance to express their feelings about their issues and they understood that it was not their responsibility, they were able to move on to the original purpose of the group. Although ambivalence, mistrust and avoidance were characteristic of the first stage, the group provided a safe avenue to explore past and current histories. This was apparent from the many personal disclosures heard. Almost all members admitted that they had been victimized and some were able to describe details. Many participants were initially reluctant to engage in the activities relating to addictions and these

interconnected issues. All were eventually able to do so in the group process. The group helped the children talk about the stigmatization of addictions and to recognize that this is not a family legacy they must bear; it provided hope for a future in which they will be able to take control of their lives and be safe.

EVALUATION

When choosing an evaluation method it is of the utmost importance is to keep the tool brief, simple, age appropriate and wherever possible, culturally appropriate. A questionnaire that is adaptable to children who have academic lags or delays is fundamental. Not surprisingly, many participants, adult and child alike, do not want to fill out lengthy, detailed questionnaires (Toseland & Rivas, 1998).

Toseland & Rivas (1998) suggest several approaches when evaluating the successful resolution of group objectives. The target of the evaluation and the method are chosen and coordinated with the facilitator's outlined objectives. For the purpose of this intervention the goals of the group and the goals of the individuals were considered. Formal and informal evaluations took place to assess the value and effectiveness of the group intervention included in the group evaluation procedure. The facilitators' notes, follow up interviews, as well as a self reporting questionnaire and pre and post group testing were used in order to examine changes in behavior.

Group goals and individual goals determine the chosen evaluation tools (Rivas & Toseland, 1998). The primary goal was to increase self-esteem by increasing qualities that contribute to it, such as locus of control. The secondary goal was to assess the influence of a psycho- educational approach in this population. Standardized questionnaires such as the Rosenberg Self Esteem Scale, monitoring behaviors and exhibiting alternative coping skills contributed to the formal evaluation of the group intervention.

Self-Anchored Scales

Self-anchored scales consist of developing individualized scales to measure the targets identified. Tailor-made, they can be used with any population to evaluate interventions, including use for obtaining different perspectives on the same dimension, such as client self rating scales, and practitioner scales. They are relevant to other parties and can be used by independent evaluators (Bloom and Fischer, 1999).

Self-anchored scales are "all purpose measurement procedures" (Bloom, 1999) that allow for flexibility, while requiring minimal time to administer and score. Used in conjunction with standardized measures, self-anchored scales can be supplemental and can provide measures of the intensity of a problem; they can evaluate the internal thoughts and the intensity of those thoughts not tapped by standardized measures (Bloom and Fischer, 1999). The face validity and ability to rate client change over time is high using self-anchored scales.

Self anchored scales and rating scales were completed. Data collection from these instruments was repeated throughout the group process at predetermined intervals; specifically, following the completion of each session. Kazdin (1981) argues that such time series measurements strengthen the inferences that the change is detected internally and is not the result of extraneous factors. Kazdin (1981) also points out that the magnitude of change and the number of cases showing change strengthens inferences that these changes have resulted from the impact of treatment. Bloom and Fischer (1999) describe the utility of such scales in that they are able to evaluate internal thoughts and

feelings. The high face validity of these measures makes them prone to reflect other influences as well as the influence of the concept they intend to measure.

Examples of self-anchored scales (Appendix E, Appendix H) were constructed based on common client goals. These examples were shown to group members at the first session. Each scale had nine points, with each point representing a different degree of intensity of the problem. The themes of the scales were: Extent of Feeling Positive about Self, Extent of Participation and Who is In Control: You or the Problem. The anchored points for the first scale were: "can't identify anything positive about self" (1) and, "there are many positive things about me" (9). The anchored points for Extent of Participation were: not participating at all (1) and total participation (9). The third scale was in graph form, with the horizontal measure indicating the session number and the vertical measure indicating the intensity of the problem being 'in control'. (1) "I am in total control", (5) "I am in control half the time", and (9) "the problem is in total control". Data from these instruments was collected at predetermined intervals. A higher rating over time was the desired direction of change for each scale.

Therapist rating scales.

Two 9 point scales (Appendix H) were completed at the end of each group session by the co-facilitators. These scales rated group members on two dimensions: (a) the extent to which client participates, and (b) extent to which client makes positive self statements. The points one, five and nine, on the Extent to Which Client Participates scale were anchored with (a) never participates; (b), participates half the time; and (c), always participates; respectively. Similarly the points one, five and nine on the Extent to Which Clients Make Positive Self Statements scale were anchored (a), never says a

positive self statement; (b), will say positive self statement; and (c), always says positive self statements. Bloom and Fischer (1999) warn of the limited reliability and validity of such scales due to the fact that their utility is based on inferences made by the therapists completing the scale. However, they do point out that such scales have merit as a supplementary instrument to self anchored and standardized scales (Bloom and Fischer, 1999) A higher rating over time is the desired direction of the change for each scale.

Finally, in an effort to ascertain the comprehension and integration of the material presented, the participants were presented with an educational learning scale (Appendix I) during the follow up interviews. This scale consisted of eight statements in which the members were asked to respond by selecting 'true' or 'false'. This survey was developed based on common misunderstandings about substance abuse and addictions in the general population.

Caregiver rating scales.

Following the facilitators' weekly post session completion of self anchored scales, caregivers of the group members were asked to complete one scale, Extent to Which Client Makes Positive Self Statements (Appendix F). Points one, five and nine on the Extent to Which Clients Make Positive Self Statements scale were anchored (a), never says a positive self statement; (b), will say positive self statement; and (c), always says positive self statements, as noted previously.

Standardized Measures

One standardized measure was used, the Rosenberg Self Esteem Scale (Appendix J), to assess the dimension of the COAs sense of self worth in relation to others. This

measure takes little time, is straightforward and can be carried out in a group setting. Scoring this instrument is simple and requires very little time as well.

The Rosenberg Self Esteem Scale (RSE) has excellent internal consistency (.92), and test retest reliability is also excellent (.85 and .88). The concurrent, known groups, predictive and construct validity are also demonstrated by research. The instrument correlates significantly with other self-esteem measures such as the Coopersmith Self Esteem Inventory. Similarly, the RSE correlates predictably with measures of depression, anxiety and peer group reputation, and demonstrates good construct validity.

The instrument taps only one dimension of self-esteem; that is, self-acceptance where the individual believes simply that he is "good enough". Accordingly, the individual with high self-esteem respects himself for who he is, and does not compare himself to others. He feels neither superior nor inferior to others (Rosenberg, 1965). A low score on this instrument indicates high self-esteem and high score indicates low self-esteem. This clinical tool was administered as pre test and a post-test instrument.

Log

The facilitator log format serves several purposes. It is a standard of comparison for the self anchored scales, and the Rosenberg Self Esteem Scale. Logs provide an indicator of reliability, but most importantly, complement the quantitative data derived from the measures with a qualitative balance (Bloom and Fischer, 1999).

The purpose of the use of logs as a supplementary measure is threefold. It supplements the data from the standardized measure. The necessity of additional time consuming measures is therefore avoided. This allows data from measures to be complemented without overwhelming the client(s). While limited in the provision of

validity and reliability, the log provides data abounding in qualitative and descriptive value, which lends itself to objective review over the course of the intervention. In charting the data, an ongoing record is created.

Unfortunately, the log has no basis in reliability or validity and cannot imply cause or effect. Changes may be the result of a change in a facilitator's perceptions, intentional distortion or under or over reporting. In an effort to counteract these threats, the facilitators were cognizant of how dependent the outcome of the intervention was on their ability to be honest and accurate in their recordings. The independent observation by a third party was used to gauge the accuracy of the client's recordings.

In this writer's opinion, the benefits of logging far outweigh the limitations. Utilizing a log enhanced the practicum by providing a qualitative perspective of the participants, which was incorporated into the evaluation process. Logging offers an easy and inexpensive means by which to compare collateral quantitative evaluation methods, supplementing the overall perspective of the intervention and its strengths and weaknesses. By virtue of the utilization of a third, more subjective means, logging enabled the results of this intervention to be generalized to a more varied base.

Data Analysis

The data supports the belief that it is reasonable to execute a child focused intervention for children of substance abusers, utilizing a psycho educational approach. Coupling time series data and pre/post follow up data is a useful strategy. The incorporation of quantitative and qualitative perspectives generates a fuller picture including the concise, standardized and subjective interpretation of the participants' experiences. This evaluation proved to be integral as an aide to practice, but its

limitations included that the repeated use of measures, at close intervals, which increased the probability of biased data. Evidence of this was noted in the participants' impatience in completing the measures repeatedly and thus their tendency to simply select any score rather than considering the question being asked. Facilitators addressed this by making every effort to remind them of the importance of accurate data, and assisting them in working through the scales accordingly.

A simple visual analysis of the observed changes in the data was documented. Bloom and Fischer (1999), suggest this offers a clear picture of the data moving through the baseline/assessment phase to the intervention phase and follow up periods. This type of analysis would note any changes (positive or negative), as well as if there is no change at all. Consideration of the data at any point during the course of the evaluation allowed the opportunity to revise an intervention or a particular aspect of the approach (i.e.; timing). Further, overall accountability is supported by differences seen in data between phases.

Dimock (1976) suggested a thorough group evaluation occurs when the group dynamics and development are observed. Weekly facilitator's group and individual progress notes should be included. Anecdotal information about the children offers a qualitative perspective regarding the influence of the group process. It also supports the construct of empowerment, i.e.; client as the expert. Evaluation provides the opportunity to ensure goals and objectives are met by the group intervention. In an evaluation process facilitators can assess the strengths and weaknesses of their own skills, or of the program, and it can highlight areas for improvement or modification (Toseland & Rivas, 1998).

Participants were asked to complete an informal "client satisfaction questionnaire" (Appendix K) at the culmination of the group intervention. This tool was intended to provide feedback and evaluate the group process for the children. Evaluation included in the questionnaire was in a set format. As well, evaluation material was completed by facilitators. Follow up interviews were held two weeks post termination of the group, and presented an opportunity to share information, and make recommendations for further programming based on feedback received. Caregivers were also asked to complete a client satisfaction questionnaire (Appendix L). Finally, both individual and group summaries were completed on each participant and provided to the referral source upon request.

Pre Test Post Test Analysis

The purpose of the data analysis was to determine whether or not there was statistically significant change in client scores from the beginning to the end of group. Visual assessment was completed for all measures excepting the Rosenberg Self Esteem Scale (RSE), which is a standardized measure. The mean difference for RSE scores at pretest and posttest were compared to determine if there was change in client's scores. The results analyzed are from the 12 clients who completed treatment the group program (see figure 1).

Rosenberg Self Esteem scale.

A lower score on this scale is indicative of improved self-esteem. Findings suggested that there was a marked increase in the degree of self-esteem amongst all participants. In the Tuesday group, the pretest mean of 26.8 (sd- 2.227) was decreased to a posttest mean of 23. Further, this improvement of self-esteem was significant (t= 3.82,

df= 4, p=< .05). Thursday's group was similar. A pre-test mean of 27.16 (sd=1.72) was decreased to a post-test mean of 24, indicating a significant improvement in self-esteem (t=5.49, df= 6, p=<.05).

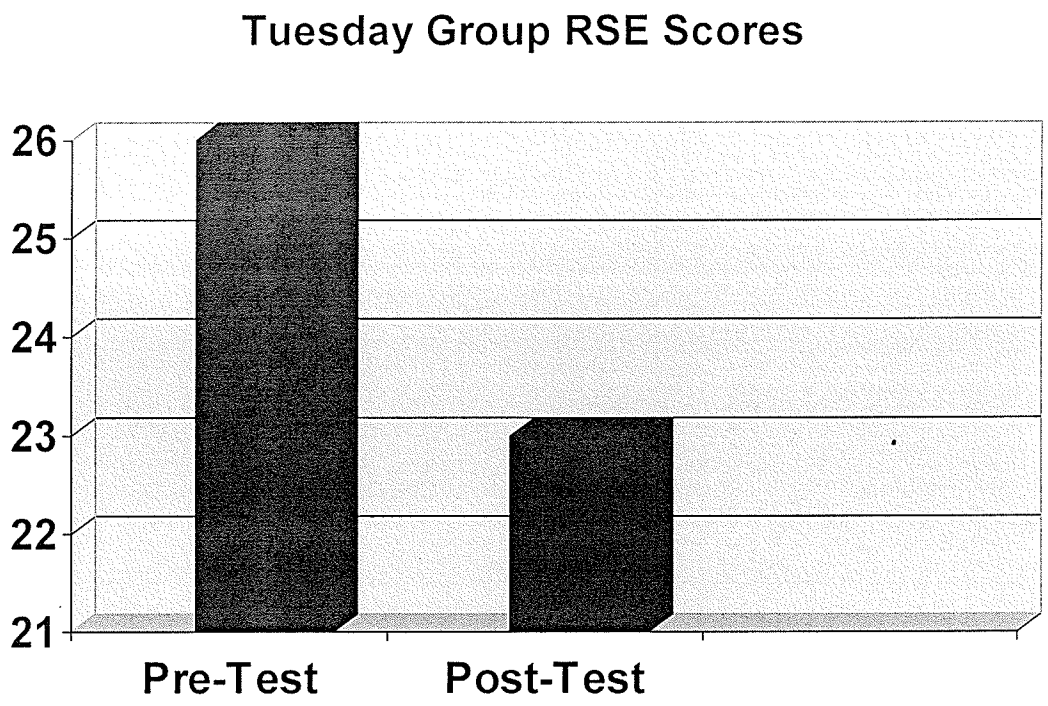

Figure 1

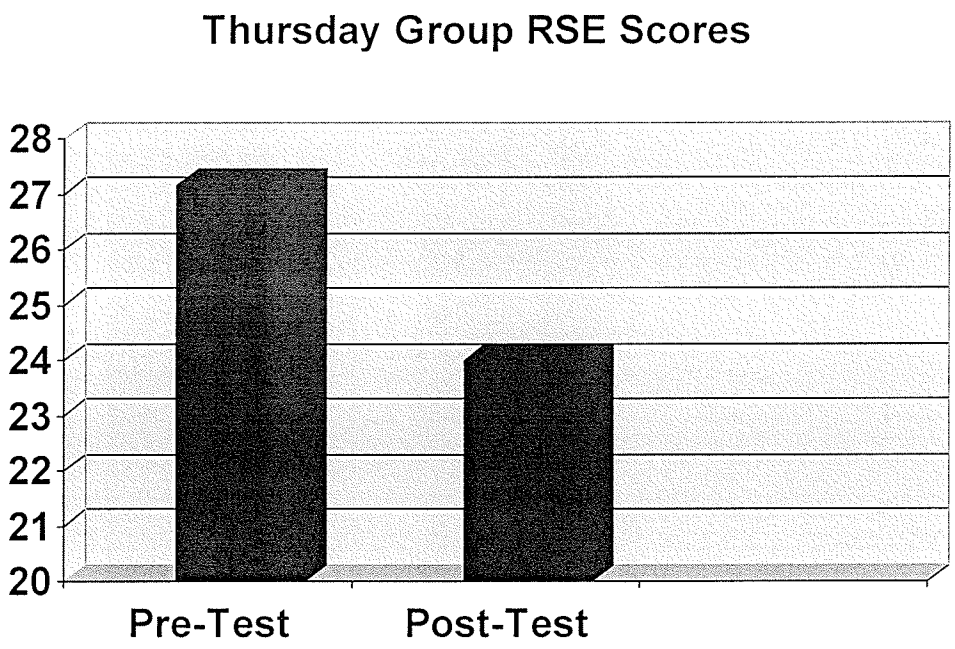

Figure 2

Self anchored rating scales.

In the self-anchored measures, results indicated an overall pattern similar to the RSE. Both groups had individual and average scores that stayed the same or increased through to the completion of sessions, indicative of positive effect (see Figure 3 and Figure 4). This pattern is evidenced in both the participants and the therapists' self anchored scales. However, because these scales are not standardized, this assessment is not generalizable to all COA populations.

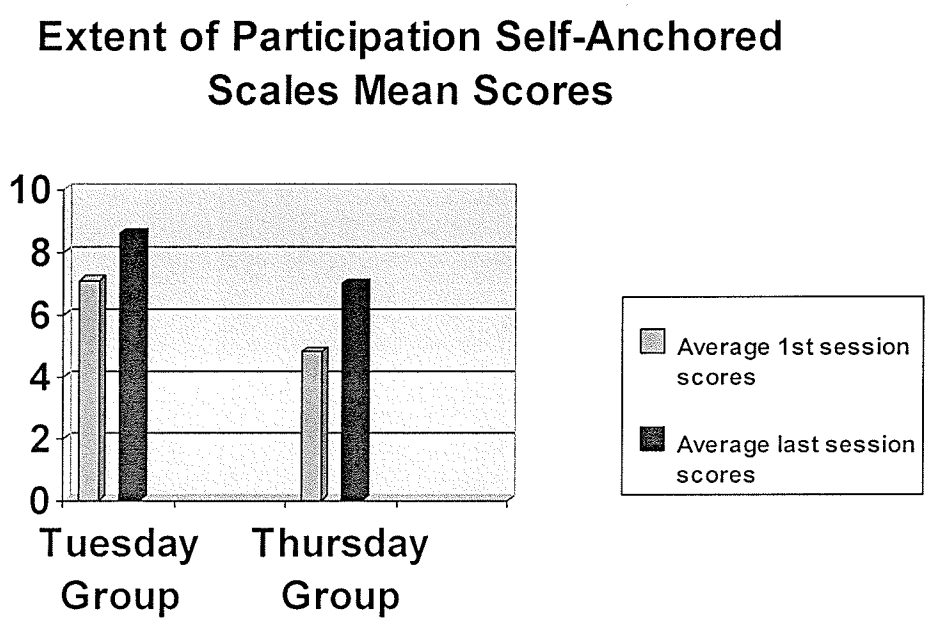

Figure 3

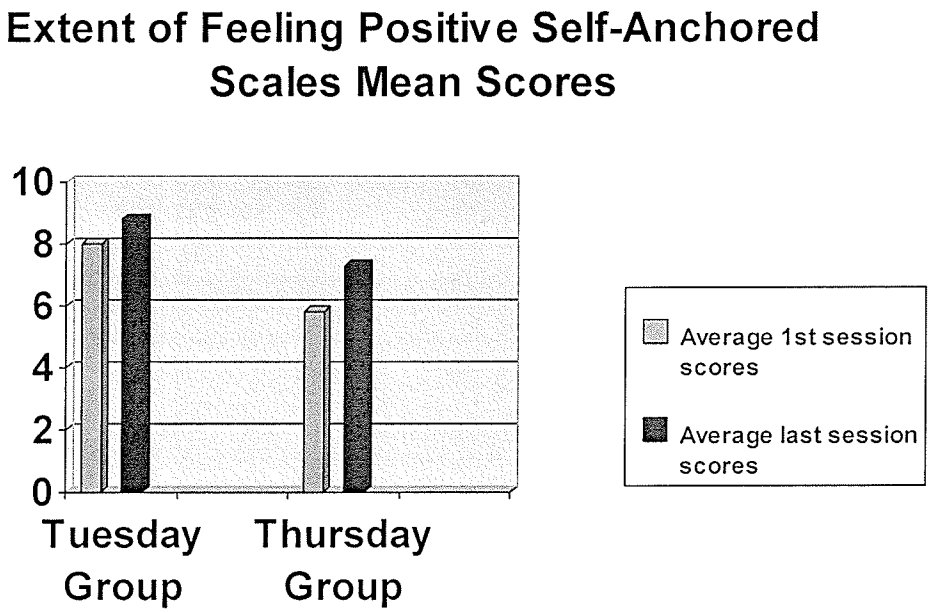

Figure 4

Table 5 represents the individual scores of the RSE pre test and post test as well as scores on the two self anchored scales. These are not group averages but rather,

individual members' scores for both groups. The RSE scores display the significant change in direction. However, with all scales the members' scores either showed change in the desired direction or remained the same.

Table 5: Summary of Client Completed Measurement Scales

	Age	Gender	RSE Pre	RSE Post	SA 1 Average	SA 1 Session 1	SA 1 Session 8	SA 2 Average	SA 2 Session 1	SA 2 Session 8
A	12	F	28	25	8	7	9	8	7	9
AA	10	F	28	26	8	7	9	8.4	7	9
B	9	F	26	22	9	9	9	9	9	9
BB	11	F	26	19	9	9	9	8.3	7	9
C	10	F	22	21	8.6	8	9	8	7	8
D	10	F	29	26	6.12	4	9	8.37	8	9
DD	9	F	29	25	9	9	9	8.42	5	9
E	11	M	20	20	9	9	9	9	9	9
EE	9	M	30	25	4	4	6	5.29	4	7
F	11	M	29	25	7.37	5	8	7.85	7	9
FF	13	M	34	28	5.88	9	8	5.75	3	7
G	6	F	25	22	5	2	5	6	2	7

SA 1: Self Anchored Scale "*Extent to Which Feeling Positive about My Self*"
SA 2: Self Anchored Scale "*Extent to Which I Participate in Group*"

Facilitator perception versus self perception.

When observed at a more stringent level, there were some differences amongst individual score patterns within groups. The participants' scores were higher and had less of a range than those assigned by the facilitators'. See Figure 6. Individual scores did not consistently increase. Rather, they increased and decreased in no predictable order. This could be attributed to any number of variables. Slight changes in mood could affect perspective on any given day. This would disallow a true, consistent subjective rating. Reactivity also makes participants prone to become lax in the use of the measure for its intended purposes. Finally, differences between self and therapists' scores may be

related to differences in perceptions of the same events or behaviors, since the scales are subjective. Overt observations that would be interpreted by therapists may not be representative of covert work that is internally occurring and therefore measurable only by the participants.

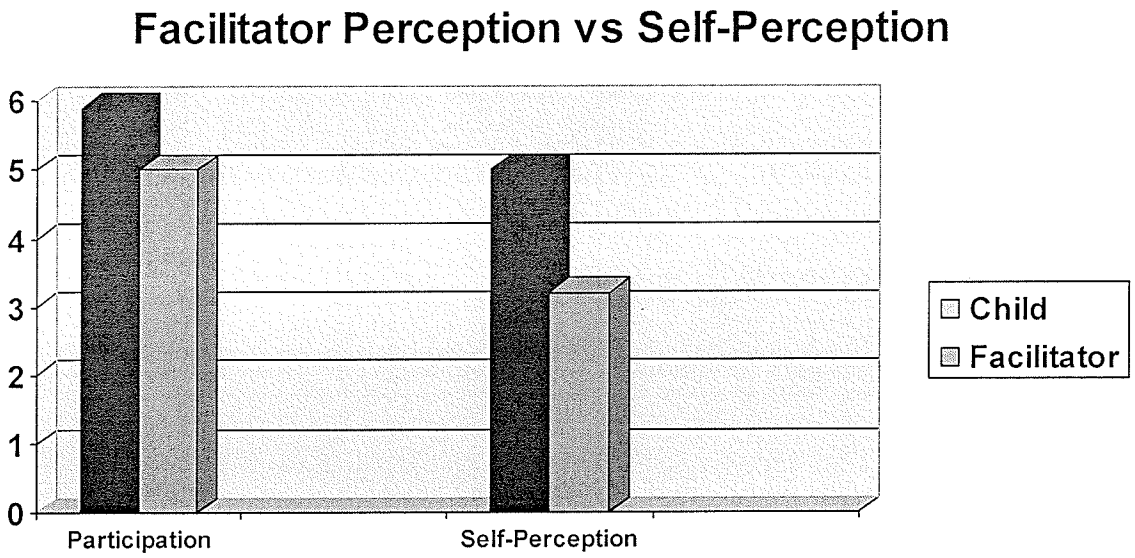

Figure 6

The therapists' scores tended to be lower individually and more consistent in their pattern of increasing. This difference may be attributed to the Bloom and Fischer (1999) warning that such measures may have limited reliability and validity due to the fact that their utility is based on inferences made by the therapists completing the scale. In spite of this risk, the scales do have merit as a supplementary instrument to the self anchored and standardized measures (Bloom and Fischer, 1999).

Caregivers of the group members were provided with additional scales. Despite repeated encouragement to complete and return the scales, too few were completed and returned to warrant any analysis and comparison. While the general trend seems similar, this writer questions the underlying reasons for the variations. At a general level, these

results would be consistent with the scores on the RSE. Certainly, the positive effects suggested by the Client Satisfaction Questionnaire and by the follow up interview with both participants and their caregiver add credibility to the positive effects suggested by the Self Anchored scores.

A third scale was used to measure for locus of control. It was in graph format, with a horizontal measure to indicate the session number and a vertical measure to indicate the intensity of the problem being "in control". This measure was collected following each meeting. A higher rating over time was desired. No discernable individual or group pattern emerged resulting in it being disregarded, having offered no analytical value. Again, fluctuation in either direction suggests that some other variables may have been at work, or that familiarity with the scale affected the quality of the measure.

Log.

The original intention for the log had been as a supplemental comparison for both the members and therapists. Primarily, it was to provide a complement to the quantitative data derived from measures by providing qualitative balance (Bloom and Fischer, 1999). It became evident in the comments of the membership at the first sessions that for them, journaling was not productive and "felt too much like school work". Since this could only be counterproductive to the goals and purpose of the groups, the decision was made to continue with the therapists' logs, while the participants were not asked to engage in this process.

Logging by facilitators enhanced the practicum by providing a qualitative perspective of the participants from the two facilitators' perspectives. Logging done by

each facilitator validated the other's perspective and thoughts on where to proceed for the following session. It provided anecdotal information about the members. It offered a qualitative perspective about the effects of the group process. Anecdotal information supports the construct of empowerment, i.e.; the client as the expert. Overhearing comments amongst the group members bore this out. What was presented at group often was talked about between the members during unstructured times at sessions. The facilitators were pleased to hear the members describing concepts correctly and the context of newly acquired information and material was comprehended. This told facilitators that the members were internalizing the presented materials and viewed themselves as experts on how to make good decisions for themselves. Together with self and therapist anchored scales and the RSE, logging proved to support and validate the emerging positive pattern.

Consumer Satisfaction and Feedback

Two instruments were used to obtain consumer feedback for this intervention. One of the instruments was a modified version of the Client Satisfaction Questionnaire (Larsen, Attkinson, Hargreaves & Nguyen, 1979). This measure indicated that overall, the participants were very satisfied with the service they received. All of the children said they received the kind of service they felt was helpful and wanted. All would recommend the program to friends. Satisfaction with programming was indicated by all respondents. All reported that they would most definitely come back to the program, and many asked if they could.

The client satisfaction questionnaire also allowed for the participants to make additional comments if they wished. One written comment stated that the supportive

people and trust in facilitators was excellent in quality and helped to make the experience productive.

The evaluation form supplied to the caregivers was similar, providing another perspective. Caregivers described information congruent with the feedback of the participant'. Though the caregivers' return rate was significantly less at 30%, those participating concluded that they felt the quality of service was excellent, and most of the children's needs had been met. Kid's Power! would definitely be recommended for other parties and the idea of the children participating in another group was welcomed.

Closing Interviews

Each child and his/her caregiver were given an opportunity to attend a closing interview two to three weeks after the final group session. This provided a helpful overview of the group process for the each child, and an opportunity for the children to verbally comment on their group experience.

These interviews were approximately half an hour in length. In these interviews, all group participants indicated that they felt that the group process had been helpful. Each commented that the group had given him/her a chance to learn about addictions and understand them better, and to know that he/she is not the only child dealing with this issue. The majority stated that they felt less isolated and more able to understand their own feelings and their behaviors related to their feelings. Specifically, "I used to know lots of kids whose parents were drunks, but I didn't know any of them felt the same way I do". Another participant commented that the group "helped me think about the problem as not really mine, unless I make it mine". Again, this feedback is congruent with the general pattern found in the RSE, the Likert Scales, Client/Caregiver Satisfaction

Questionnaires and logged observations. In spite of the erratic nature of the individual scores across the self anchored scales, the supplemental tools supported the general pattern. Specifically, self esteem increased and the participants integrated the information as outlined in goals and objectives for the group.

The locus of control graph was disregarded altogether following a visual analysis which revealed it to be undependable and without an established pattern. This is not a measure that would be recommended for use with future groups as the concepts and language may be too abstract for the population being treated; this issue is consistent with Erikson's (1963) theory of developmental stages.

Finally, in an effort to ascertain the comprehension and integration of the material presented, the participants were presented with an educational learning scale (Appendix I) during the follow up interviews. This scale consisted of eight statements in which the members were asked to respond by selecting 'true' or 'false'. This survey was developed using common misunderstandings about substance abuse and addictions held in the general population. While not completed to by all, the majority of the results were further indicative of the participants having integrated and comprehended the material being offered to them.

Variables Impacting on Results

Any number of individual or general variables could and may have impacted on the observed patterns. The most obvious variables were the membership of the groups, the age of the participants and the living arrangements of the participants. As noted, the great variation in ages certainly posed a major potential issue. The factoring in of developmental balance leaves age variances as less of an issue. This writer was surprised

at how the age difference amongst members served to make them more cohesive and higher functioning as a group. Participants' differing levels of development complemented each other, serving as a source for the children to come together and help each other in balancing ways. This was the opposite of what was anticipated. It was feared that the possible gaps in development would serve to limit cohesion and add negatively to the group dynamics. By providing flexible and simple terminology and hands on activities, all of the different developmental levels among the children were accommodated. Consistent with an Eriksonian perspective, the purpose of this population's stage to develop feelings of increased independence is supported. The children themselves demonstrated the development drive.

Another considered variable was the living arrangements of the membership. However, as noted, all the children were living outside of their birth homes and had been for some time. Therefore they were homogenous, and permitted no inferences between variance based on this issue. Possibly, a relevant variable may have been clarity, or lack thereof, for a long term care plan for each participant. Some of the children knew they would not be returning to their family of origin while others did not. Some children had been in care for many years, others only for a few months. The children appeared aware of their different care patterns through group dialogue on the topic. Openness to the true reality of addictions as a debilitating factor may have been mediated by this, impacting on the results. The participants' results were compared after reviewing their care plans as previewed by their legal guardians, but no pattern emerged.

Any number of reasons exist for the variation amongst individual scores on the participants' scales. Completing the scales following every session contributed to some

disregard and boredom with the measure. This undermined the importance of comprehension and dependability as they related to excessive exposure. Subjective interpretation of the scales may also provide some insight into the incongruence between the individual scores of therapists and participants. In the end the overall pattern prevails, supported by the supplementary collateral tools (logging, personal interviews, client/caregiver satisfaction questionnaire).

In conclusion, the RSE and the client/therapist self-anchored scales suggest that the group goals and objectives were attained. Self esteem and sense of power amongst the participants increased by means of the themes integrated through the experience of hands on activities. The Educational Scale designed for this practicum provided evidence that the psycho-educational approach supplemented this effort. The client satisfaction questionnaire indicated that all of the participants and their caregivers that responded were satisfied with the group process, though many indicated that it was not long enough. Caregivers often commented that they were concerned that the children would not continue to have a resource like this available to them in the future. Kids Power! funding becoming a mainstay of the resources available through any social service agency is one way to ameliorate such a concern. The most significant outcomes of the group process appeared to be reduced isolation, and awareness of how to manage chronic addiction and the experience of acquiring skills to cope in a healthy way with an unhealthy situation.

Learning Objectives

This clinical practicum attempted to meet several of the writer's learning objectives. One of the initial learning goals of this practicum was to provide an

educational and supportive environment for COAs. Those children completing the group stated that they appreciated the things they learned and the support of the group. None of the participants stated anything to the contrary, nor did any of the children discontinue their attendance at group. The majority of the social workers and caregivers of the participants commented that they had exhausted their efforts to find a group resource for COAs and were pleased to finally have an option. It is argued that the group intervention created a safe environment that offered the COAs in attendance a learning format. At the end of the group, all children could identify that he or she had learned something new about their situation.

All could identify what the dynamics of addictions were, define addiction, and provide analogies and examples of alternative coping strategies for children dealing with addiction in their families. Some of the children had difficulty releasing the responsibility for maintaining the family unit in exchange for their own safety as evidenced in the responses to the Educational Scale (Appendix G). Item two was often indicated to be 'true'; that 'if I try really hard, I can stop he/she from using'. When elaborating on this response, participants were clear that they knew this was not an accurate statement, it represented a hope held out. However, the majority of them were able to comfortably integrate this into their cognitions by the final session. The group provided the children with the opportunity to explore self monitoring and coping techniques and responses they could utilize in the future to maintain themselves and get what they need to become healthy and productive adults. The group afforded strategies for healthy coping and a place to practice alternative problem solving and social skills. In turn this success

supported the goals of encouraging the COAs to develop the ability to make positive choices respecting the way they choose to live their lives.

The goals of broadening and practicing the writer's clinical social work skills with small groups; becoming more familiar with cognitive theory, and group work theory, particularly as it pertains to children of alcoholic/addictions were achieved. The knowledge attained from the extensive review of the literature on the subjects was informative. As well, it was a luxury to have such intensive clinical supervision. It greatly enhanced the learning process and expanded this writer's clinical perspective. Throughout the group process, this writer was challenged to practice social work and group skills in ways that had not previously been explored. An experienced and creative co-facilitator gave this writer the opportunity to further grow and actualize the use of the skills in cognitive, narrative, solution focused and small group work. These skills were encouraged and supported in this writer throughout the group process. The debriefing following each session with the co-facilitator was valuable in the development of these skills. Additionally, having a co-facilitator of the opposite sex provided valuable perspective and potential resource for the male participants when very sensitive secondary victimization issues were broached. Certainly there was professional growth in this area.

Increasing the facilitator's comprehension of and skill in using standardized and self anchored assessment measures was evident. Differences between the results of the RSE scales, the self-anchored scales, and the logs highlighted the value of using multiple measures. It validated the intervention. The changes in the desired direction from pre test to post test were confirmation that the session planning was appropriate. If the

changes had been contrary, then the writer would have an indicator of the need to adapt the session planning. The writer recognizes the merit of using both standardized measures coupled with logs or lichert scales. The two compliment each other and bring more depth to the ongoing group evaluation of the process. Having a variety of evaluation tools allows for the consideration of spurious variables impacting on the individual measurement scores.

The importance of the formatting in scales was noted. The wording used in the Self Anchored scales needs to be simple and relevant to the population being addressed. If this is overlooked, the measures become ineffective due to poor comprehension of those completing them. Participants can easily become overwhelmed with too many measures, compounding this issue. Facilitators also need to be flexible and creative in formatting group activities, embracing lots of options, to successfully move participants through material. For example, when the bicycle game was not working with one group, the facilitators chose to review the previous weeks' agenda rather than completing the original activity. Children need lots of activity. Activity is helpful in engaging and integrating participants into the group process.

Johnson and Johnson (1997) discussed six factors that are useful in assessing the effectiveness of a group. A group has been deemed effective if the following variables were observed (1) clear group goals were identified; (2) group members communicated feelings and ideas accurately and clearly; (3) members participated and provided leadership among themselves; (4) members influenced each other; (5) members showed flexibility in decision making procedures; (6) members disagreed, challenged each other and showed controversy (Johnson and Johnson, 1997). In review, these groups shared

clear common goals. These included; (1) to develop an understanding that alcoholism is a disease; (2) facilitate an acceptance of limitations in controlling the addict's behavior; (3) learn healthy alternatives to coping for themselves; (4) foster and practice alternatives (i.e.; problem solving skills); (5) decrease sense of hopelessness (i.e.; self esteem, locus of control, etc.) as evidenced in data analysis, (6) and develop an awareness of feelings. Members communicated their feelings clearly and effectively, influenced each other and were involved in conflict. For the most part, all members participated and a majority showed leadership. The members used problem-solving techniques and were flexible in decision making processes. Having met the above six factors, it appears this was an effective group.

Implications for Future Social Work Practice with COAs

Undertaking this practicum has been both demanding and rewarding. For the student it has been an opportunity to research available information on COAs. The result of this has been an increased understanding of the effects of substance abuse on COAs and the types of interventions that can assist them the most in coping and raising self esteem. The support of skilled individuals has further contributed to learning. Specific concerns were discovered as a result of this exploration of short-term group therapy with this population. The succeeding paragraphs will elaborate on each of these themes.

This practicum has highlighted several important considerations when working with children of alcoholics. Primarily, it is emphasized that COAs between the developmental ages of 8-11 are a population with few if any group resources. Social service and mental health policies do not address the fact that this population is one that "falls through the cracks". By the next developmental stage, the opportunity to intervene

successfully may have been lost. There are no systems in place that respond proactively to this population to lower the risk. Children are constantly placed at risk until the situation becomes a "protection issue", warranting Child and Family Services involvement. There are too few resources that are exclusively for these children.

Secondary issues to addiction, such as sexual, physical and emotional victimization as well as neglect resulting in physical, developmental and social delay remain at the forefront. Regardless of the stage of recovery the addict is in, these issues remain permanently etched into the identity of the COA and have to be addressed. Although there are some resources available for these problems they will be rendered redundant and ineffective if the underlying source is not addressed. Unfortunately what emerges is a piecemeal effort to patch together COAs after the trauma, rather than addressing the situation at its source, from the foundation up. If this occurs, the secondary interventions, which already exist, will be more solid and effective.

Some dynamics occurred unexpectedly in the sessions, for example, unpredicted alliances between members. The quick establishment of group cohesion in both sessions was not anticipated, nor expected. The members felt connected to one another, and this was sensed early in the group process. Several participants reported on the Client Satisfaction Questionnaire that the most "fun" things experienced with the group was the camaraderie they experienced with other members. The time limit of the group did, indeed, focus the group and created some sense of urgency in covering the materials and themes outlined. Members indicated a sense of frustration and incompleteness with this process. In the opinion of this facilitator, there is likely merit in engaging the participants in longer-term group therapy.

Facilitators noted that the topic of addictions, in particular some of the secondary victimization that is often associated, was extremely sensitive and challenging to discuss. The majority of these children have been abused in some fashion, an abuse to which they have attached a stigma. Most made comments about being very angry at their caregivers/family for behaving in such a way that someone allowed this to happen. Concurrently, it was challenging to change the children's integrated ideas of who is responsible for their victimizations vs. who is responsible for the addictive behaviors.

It was noted was that some of the children had a very difficult time talking about their behaviors and responses to being victimized or to their family member's addiction. The group reacted to such discussions by disruptive and distracting behaviors that forced facilitators and volunteers to concentrate more on behavior management than on discussing the themes. It would be recommended that a group addressing such sensitive material have a small membership and low facilitator and/or volunteer to participant ratio. Further, because of the sensitive nature of the topic and related sub topics, it is recommended that other groups with COAs this age remain closed. The children need to form trusting relationships with each other to feel safe enough to share thoughts and feelings about their experiences. Having both a female and male co-facilitator seemed to benefit the group in dealing with these secondary issues and should be considered in future programming for this reason. An open forum group would have continually disrupted the formation of trust and prevented the children from feeling safe enough to disclose and discuss their own feelings, capabilities and behaviors.

It seems that a structured, time-limited group is necessary to model boundaries, create predictability and enhance the establishment of a safe environment (Mandell et al,

1989; Rose, 1985). Once children had established trust and formed relationships with each other, the group could move from non-threatening themes to more difficult themes. The structured progression of themes helped the group to move at a slow pace and according to the level of comfort of the group. Facilitators adapted the structure to suit the needs of either group, revisiting some topics before proceeding to the themes related to addictions.

The length of the group sessions proved to be adequate to accommodate the structured themes. The disruptive and distracting behaviors of the children when sensitive topics were addressed delayed the progress through the group material to some extent. However, because the length of the sessions could not be modified to any great extent, flexibility respecting the types and number of activities became paramount. Particularly beneficial in this intervention was integration of physical activity breaks into the break time allotted.

This group intervention was only eight sessions in duration. Most of the children said they felt that this was not a long enough time. Many of the group modules could have benefited from more time to integrate the material and complete additional activities to assist in this process. The original outline of group sessions could have been further broken down into additional modules spread out over a longer period. Therefore the amount of energy and time spent dealing with distracting behaviors would not detract from the time needed to integrate difficult themes.

The completion of scales and measures required of participants throughout the sessions was both helpful and a hindrance. While necessary to evaluate the intervention, it became apparent that for these participants, there were too many scales with too much

detail required to likely be adequately completed. It was possible that the members simply completed the weekly scales without consideration of accurately portraying what was asked. Evidence of this is seen in the discontinued use of the locus of control graph. In hindsight, fewer scales with more child friendly text would be recommended. For instance, instead of asking "the extent one feels positive about self" it would have been worded as "the extent I like myself". The participation scale would be excluded as the format itself was confusing. The remaining positive thoughts scale could be reformatted from one to three at anchored points. While it recommended in the literature that the construction of self anchored scales should have five or greater points it would be too much for the group in this particular intervention. The term 'happy' to replace 'positive' would be more comprehensible to the participants.

As a children's group, one of the most beneficial aspects for the COAs was being with others and listening to their own experiences. The group was effective in alleviating isolation and alienation that some of these children felt, even amongst their own sibling group. Interestingly, the anticipated sibling's negative dynamics was not experienced to any extent, which is at odds with the literature. Certainly, this can and did present an issue for one of the dyads participating. At the same time, it did not pose any such barriers for a second pair in a separate group. It became apparent that sibling dyads should not automatically be separated and that the dynamics can be quite productive in the therapeutic environment.

In the same vein, it was noted that the warnings against having too vast an age range within groups may not be valid. In fact the wide range worked quite well in this instance. Perhaps this had more to do with the personalities of the participants. At any

rate, the age and developmental differences served to draw the children closer and to become more cohesive. They actively participated in their learning and exchanged between members contributing to the group culture and overall success. Depending on the type of group and the theoretical underpinnings used, this may not always be the case. Here, COAs as a group seemed to defy the references in the literature and to benefit greatly from the age and developmental mix. There should be flexibility in the format and activities so that a range of abilities can be accommodated.

It was also clear from this intervention that because the families of addiction function in a "one day at a time" manner, the children often do not have a lot of direct support from their addicted caregivers. This may be reflected in the fact that all the participants were at least temporarily residing outside of their birth homes. Those that returned to their birth homes did not end up attending. The issues for the children and their caregivers are very separate. It is valuable to approach treatment as such in order to help COAs build themselves into independent and functioning young people. To avoid compromising this effort, the focus must be on the children and their perspective and their abilities. Children may recover, regardless of impact of their caregivers.

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Appendix A

KID'S POWER GROUP

For children in families where there is substance abuse

This is an 8 week group intervention for children (8-11 years old) who have been exposed to substance abuse in their families. Group sessions will be held once a week (1 1/2 hours each session).

Weekly Themes will include:

**Understanding addictions and how it effects families*

****Feelings about people who are addicted***

****Coping skills***

**Self Care*

**Anger Management*

**Choices/Change*

Criteria:

*Children aged 8-11.

*Children who are living in or have lived in homes where substance abuse is/was occurring.

*Children living in or out of the home. Who exhibit social and/or behavioral problems related to substance abuse of a family member.

Starting in February 2003 (evening sessions)

To Refer: Call Sara Yager,

Appendix B

Kid's Power Referral Form

Please return to: Sara Yager

2nd Floor, 835 Portage Ave.

Winnipeg, Manitoba

R3G ON6

944-4195 (phone)

944-4250 (fax)

1. Child's Name & Date of Birth:

2. Parent/Caregiver's Name/Legal Guardian , Address,& Telephone Numbers:

3. Name, Address & Telephone Numbers of Professionals involved with the child, who may provide crisis management.

4. Referring social worker & organization

5. How long has the child/family been involved in your program? How long do you anticipate being involved?

6. Is there Child and Family Services involvement and if so, for how long?

7. Other Agency involvement? Any past or present therapy?

8. Provide a brief description of the child's behaviors as they might affect group dynamics. How might your child benefit from a group experience?

9. Provide a brief description of the family of origin/situation dynamics that have resulted in this referral for intervention.

10. Any other pertinent information?

Appendix C

CONSENT FORM

I, ---------- , parent/guardian of ----------, consent to allow ----------, to participate in sessions of KID'S POWER!. I further consent to allow ---------- to be videotaped participating is the sessions, with the understanding that the tapes will be used for educational purposes only.

Parent/Guardian

Parent/Guardian

Witness

Appendix D

Suggested Questions For Screening Potential Group Members

How did you hear about this group? Have you ever had a group experience before or do you know someone who has? How was it?

How do you feel about being here today?

Tell us about yourself, who are the people that take care of you, where do you go to school, who are your friends?

What is it like living in your family? Are you in contact with your birth family right?

How do you feel about your family?

How do you think it will be for you to talk about your experiences with addiction in your family in a group and hear others talk about theirs?

Have you ever talked about addictions with anyone before? What happened? What were the reactions?

Tell us in general about your experience with addictions? Who in your family is addicted? How has their addiction had an effect on your life?

How has it been to have us ask about these things and to be talking about them?

How do you think addictions affect you right now?

What are your feelings about being in a group with other kids who have experience with addictions? What are your fears or concerns about doing this?

Are you currently in any other counseling, either individual or group?

Have you talked to anyone else about joining this group?

Who can you share things with? How long have you known them?

How do you feel about us talking to your counselor about your progress at group?

Appendix E

How Much is the Problem Controlling You?

Where Did You Move on the Scale From Last Week?

I am in control 9

Problem is in 1

control

Session Number

Appendix F

Name:

Date:

Extent to which my child makes positive self statements

1	3	4	5	6	7	8	9

never says positive self statements	occasionally says positive self statements	will say positive self statements	most self statements positive	always says positive self statements

Appendix G

Name:

Date:

Extent to Which I Participate in Group

1	2	3	4	5	6	7	8	9
never		sometimes		half the time		most of the time		all the time

Feeling Positive About My Self

1	2	3	4	5	6	7	8	9
can't think of anything positive about me				Neutral				There are lots of positive things about me

Appendix H

Client:

Date/Session:

Extent to which client participates

1	2	3	4	5	6	7	8	9
never		sometimes		half the time		most of the time		all the time

Extent to which client makes positive self statements

1	2	3	4	5	6	7	8	9
never says positive self statements		occasionally says positive self statements		will say positive self statements		most self statements positive		always says positive self statements

Appendix I

Things To Think About, Things To Learn- Educational Scale Developed For This Practicum

1.	I am responsible for my family member's substance abuse	True	False
2.	If I try really hard, I can stop he/she from using	True	False
3.	It's easy to look at people and tell who is an addict	True	False
4.	My family member is an addict, so I will be one, too	True	False
5.	Many children who have a family member who uses substances feel angry	True	False
6.	People who keep using even when it keeps causing problems with family, work or health are sick.	True	False
7.	Feelings are not right or wrong, they just are.	True	False
8.	Learning to handle problems in a bad way is called coping	True	False

9. If an alcoholic stops drinking, things will get better right away True False

Appendix J

Standardized Measure- Rosenberg Self Esteem Scale

A. ROSENBERG SELF-ESTEEM SCALE

The scale is a ten item Likert scale with items answered on a four point scale - from strongly agree to strongly disagree. The scoring for some items needs to be reversed so that in each case the scores go from less to more self-esteem.

INSTRUCTIONS: BELOW IS A LIST OF STATEMENTS DEALING WITH YOUR GENERAL FEELINGS ABOUT YOURSELF. IF YOU STRONGLY AGREE, CIRCLE SA. IF YOU AGREE WITH THE STATEMENT, CIRCLE A. IF YOU DISAGREE, CIRCLE D. IF YOU STRONGLY DISAGREE, CIRCLE SD.

	strongly agree	agree	disagree	strongly disagree

1. On the whole, I am satisfied with myself. SA A D SD

2.* At times I think I am no good at all. SA A D SD

3. I feel that I have a number of good qualities. SA A D SD

4. I am able to do things as well as most other people. SA A D SD

5.* I feel I do not have much to be proud of. SA A D SD

6.* I certainly feel useless at times. SA A D SD

7. I feel that I'm a person of worth, at least on an equal plane with others. SA A D SD

8.* I wish I could have more respect for myself. SA A D SD

9.* All in all, I am inclined to feel that I am a failure SA A D SD

10. I take a positive attitude toward myself. SA A D SD

Note: Items with an asterisk are reverse scored.

Appendix K

The Client Satisfaction Questionaire

Please help us make KID'S POWER! even better by answering the questions below. Your thoughts on KID's POWER, good and bad, help us do this. Thanks!

Circle Your Answer

Did you like KID's POWER!

4 3 2 1

Extremely Somewhat Not at All

Did the group cover the things you thought it would?

4 3 2 1

Not at all Not really Yes Yes, definitely

Was KID'S POWER helpful?

4 3 2 1

Very Somewhat A little bit Not at all

Would you suggest KID's POWER to other kids?

4 3 2 1

Definitely Not Don't think So I Think so Definitely

Did you like what you learned?

4 3 2 1

Yes Somewhat Not really not at all

Would you come back to KID'S POWER again?

4 3 2 1

Definitely not Don't think so Yes Definitely

If you had a choice of KID'S POWER being done in groups or on your own, would you choose a group?

4 3 2 1

Definitely not Don't think so Yes Definitely

Are there some things you wanted to learn about but did not get a chance to talk about?

Would you add something to make this group better?

13. Were the group facilitators helpful and informed?

Comments_____

_____

_____

—

-

Appendix L

Caregiver Service Satisfaction Questionnaire

Please help us improve our program by answering some questions about the service your child has received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you for your input, we appreciate your help.

Circle Your Answer

How would you rate the quality of service you received?

4	3	2	1
Excellent	Good	Fair	Poor

Did your child get the kind of service you wanted?

4	3	2	1
No definitely not	No not really	Yes generally	Yes definitely

To what extent has Kid's Power! Met your child's needs?

4	3	2	1
Almost all needs met	Most needs met	Only a few of needs met	None of needs met

If a friend's child were in need of similar help, would you recommend Kid's Power!! For him/her?

4	3	2	1
No definitely not	No I don't think so	Yes I think so	Yes definitely

How satisfied were you with the amount of help your child received?

4	3	2	1
Quite satisfied	Indifferent/ Mildly dissatisfied	Mostly satisfied	Very satisfied

Have the services your child received helped he/she to deal more effectively with his/her problems?

4	3	2	1
Yes a great deal	Yes somewhat	No not really	No they seemed to Make things Worse

In an overall general sense, how satisfied are you with the services your child received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildy satisfied	Quite dissatisfied

If you were to seek help for child again, would you come back to Kid's power!!?

4	3	2	1
No definitely not	No I don't think so	Yes I think so	Yes definitely