CHILDREN EXPOSED TO PARENTAL VIOLENCE:

A GROUP WORK INTERVENTION

By

Raul Dimaculangan Jr.

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in Partial Fulfillment of the Requirements
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Abstract

Two psycho-educational groups for children exposed to parental violence were implemented at the Elizabeth Hill Counselling Centre. The first group included 3 children between the ages of 8 and 11 years. This group ran concurrently with a mother's group (parent-child group program). The second group included 4 children between the ages of 9 and 11 years. This group was for children only and did not include a parent component. The goals of the groups were to assist the children to identify socially appropriate ways of resolving conflicts, enhance the children's self-esteem using meaningful activities, and to provide the children the opportunity to process and understand the violence that they have witnessed. The two groups utilized age-appropriate activities to facilitate discussion around family violence. Clinical impressions suggest improvements in the children's attitudes about family violence and an increase in awareness of who is responsible for the violence. The mothers reported positive behavioral changes in their children.

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CHAPTER 1

Introduction

On September 11, 2001, an American Airlines 747 crashed into the north tower of the World Trade Centre in New York City. Several minutes later, a United Airlines slammed into the south side of the tower. Special news bulletins reported that two other planes had crashed—one hitting the Pentagon, and the other, in a field in Somerset County Pennsylvania (Chronology of Terror, 2001). By late afternoon, state officials reported that all four planes were hijacked and that there were "good indications" that Osama bin Laden, head of the terrorist network al-Qaida, masterminded the hijackings. For several months, major television networks in Canada and the United States bombarded the public with graphic images of the planes hitting the Twin Towers and people running for cover. Approximately 5,000 people including numerous office personnel, firefighters, and police officers lost their lives on that memorable and tragic day. One can only imagine the impact that this media coverage of "9/11" had on the public, especially on its young viewers.

Children are also exposed to violence in sports. The World Wrestling Federation expose children to a variety of special moves including the "pile driver", "choke hold", and other techniques designed to overcome an opponent. Fans and professional wrestlers maintain that these moves are choreographed and are not real. The National Hockey League is also notorious for its physical violence among players. One hockey fan stated, "Fighting is definitely a big part of it for me. It adds excitement. If I turn a game on t.v. and miss a fight, I've missed something." (Garret, 1998). Perhaps, for many hockey fans, fighting enhances the macho image of players and increases the entertainment value of

the sport. The question still remains, "What lesson does sports violence teach our children?"

Perhaps the most devastating form of violence for children is the violence they witness between their parents. The literature has given this form of violence different names including parental violence, domestic violence, family violence, and adult to adult violence. There is a growing body of evidence that children who witness violence between their parents are at risk of developing behavioral and emotional problems in the short and long term (Carlson, 1984; Hersen, 1990).

Of all the traumatic events that children can experience, none can be more horrific than witnessing the murder of one parent by another. Although domestic homicide is not the focus of this practicum report, the following two front-page articles describe the negative impact of witnessing parental violence:

> March 10, 2001:
>
> A heart-rending case of domestic abuse ended with applause and tears yesterday when a jury found a teenage boy was justified when he clubbed his stepfather to death with a baseball bat. The man abused his children, drank excessively, smoked marijuana, cheated on his wife, repeatedly assaulted her and threatened to kill her if she left, court was told. Only hours before he was killed in July 1999, the man was overheard threatening to "assassinate" his entire family, according to witnesses. He was attacked by his then 16-year old stepson after leaving a bedroom where he was heard screaming at his wife. The teen attacked him from behind while he stared out a window (McIntyre, 2001, pp. A1-A2).

Defense lawyer Darren Sawcheck stated after the verdict: "Regrettably, this is one of those sad cases where a person was so fearful for his safety and the safety of his family that he had to act. Children, even if they are not the direct victim, can suffer from domestic abuse just as much as the spouse" (McIntyre, 2001, pp. A1-A2).

June 1, 2001:

> He was the silent witness to a horrific crime. Just over a year ago, Owen Lepp, barely three years old, watched his mother Cory die--strangled in her west Winnipeg apartment by her estranged boyfriend Stephen Treller. He then drove the boy to Winnipeg Beach where he hid Cory Lepp's body in the crawl space of his grandmother's cottage. After that, Treller returned the little boy to his mother's Fairlane Avenue apartment, where the tot remained alone for several hours until he was found by his grandparents (McIntyre, 2001, pp. A1-A2).

Sadly, this tragic event left a lasting impression on Owen Lepp. Following this incident, Owen began to have nightmares and developed a fear of being left alone as Marj Lepp, his grandmother, shared during court:

> I see his nightmares. He worries about being left alone, as he was the night his mother was murdered. He makes wishes in a wishing well for his mother. He says 'please don't leave me,' and 'Are you turning into my mommy?' He asks over and over again which star in the sky is mommy's. Where is heaven? How do we get there? What is dead? How do you die? These heart-breaking questions leave us all physically and emotionally drained (McIntyre, 2001, p. A2).

Fortunately, the family violence literature suggests that not all children will suffer negative side effects from exposure to parental violence. The literature tends to show

that most children who witness violence between their parents will grow up to be productive healthy individuals (Groves, 2002). However, the literature also indicates that for some children, parental violence exposure can be extremely traumatizing as these two articles suggest (Falasca, 1999).

Personal Learning Objectives

This practicum was utilized to gain knowledge in the following areas:

- The impact of parental violence on children's emotional, psychological, and social development.
- The theoretical and empirical literature related to the effects of exposure to parental violence.
- How children cope with exposure to parental violence.
- The effectiveness of utilizing a group work intervention with children exposed to parental violence.

Additional objectives included:

- To develop comprehensive knowledge regarding the recruitment of potential clients, intake and assessment, and the application of evaluation measures.
- To develop a greater understanding of the group stages of development.

To accomplish these goals, this practicum involved facilitating two children's groups at the Elizabeth Hill Counselling Centre. The first children's group was implemented in September 2001 and was led by a female therapist and myself. This group ran concurrently with a mother's group for 12 weeks. The mother's group was facilitated by two female graduate students. Each week, the mother's group and the

children's group met separately for 1 hour and joined together following a scheduled break. The second children's group was implemented in January 2002 and was led by myself and a female co-therapist. This group was for children only. Parents were involved in the intake and were contacted throughout the group, but no formal group intervention for parents was offered.

This practicum report discusses the impact of parental violence on children including the short and long term consequences of early exposure. Several theoretical models are presented including social learning theory, intergenerational transmission of violence, trauma theory, a risk and protective factors model, and attachment theory. In addition, this report discusses the development of children's groups in Canada and the United States and the use of a group work intervention for children exposed to parental violence. Details of the practicum experience including the setting, the participants involved, and evaluation measures used are outlined. As well, this practicum report presents the stage model of group development and applies this model to the two children's groups. This report concludes with the practice and learning themes that emerged from this practicum. Several recommendations are offered in the final chapter of this report.

Relevance to Social Work

This practicum is relevant to the profession of social work for several reasons. One reason is that this practicum is consistent with social work's commitment to helping families. Historically, the profession has had a long commitment to helping individuals (e.g., the poor, marginalized, and disadvantaged) (Abramovitz, 1998). Social work is

committed to promoting social and individual changes (Abramovitz, 1998). The two children's groups were used to raise public awareness of the impact of parental violence on children and to promote individual changes (e.g., enhance self-esteem, teach positive problem-solving techniques).

The profession of social work is concerned with child welfare (Lieberman, 1979). The two groups that were implemented were designed to meet the needs of children who were exposed to parental violence. Children who witness parental violence are at risk of developing behavioral and emotional difficulties (Carlson, 1984). Furthermore, children who witness parental violence will learn to use violent tactics to solve problems with their peers (Carlson, 1984).

The profession of social work has responded to parental violence in a number of ways. Social workers, for example, have advocated for women and children in the legal system (Mullender & Morley, 1994). Numerous studies in Canada and the United States have been conducted to learn about the impact of parental violence on children (Carlson, 2000; Jaffe, Wilson, & Wolfe, 1990). These investigations have led to the publication of numerous articles in professional journals regarding the effects of parental violence. Social workers participate in prevention work in schools (e.g., educating students about family violence and teaching positive ways of resolving conflicts) (Mullender & Morley, 1994).

The profession of social work has also been involved in the development and implementation of interventions for victims and perpetrators of domestic violence. Interventions for women who have been abused include individual and group therapy (Carlson, 2000). Batterer intervention programs for abusive males have also been

implemented across the United Stated and Canada (Bennett & Williams, 2001). Children exposed to parental violence are most often treated using a group work format (Loosely, 1997).

Group work developed in the early 19th century in the English and American settlement houses and offered individuals opportunity for education, recreation, and socialization (Toseland & Rivas, 1998). During the 1940's and 1950's, group work was utilized by social workers to provide therapy and remediation in mental health settings (Toseland & Rivas, 1998). In the 1960's, the maltreatment of women and children received increased attention following Henry Kempe's (1962) study of the impact of domestic violence on children (Ammerman & Hersen, 1990). According to Kempe (1962), children exposed to parental violence suffered from "Battered Child Syndrome."

The work of Kempe (1962), Jaffe et al., (1990), and Peled and Davis (1995) underscore the importance of early intervention with children exposed to parental violence. Group work appears to be an effective treatment for this population. It is for this reason that this practicum is relevant to the field of social work.

Finally, this practicum contributes to the existing knowledge of the effectiveness of a group work intervention with children exposed to parental violence. In "Research Methods in Social Work", Rubin and Babbie (1993) note the importance of social work research:

> The main reason to utilize research is not to meet our own needs to be professional or for job satisfaction. The main reason is compassion for our clients. It is because we care about helping our clients that we seek scientific evidence about the effects of the services we are providing them or of alternative

services that might help them more. If the services we provide are not effective, and if others are, then we are harming our clients by perpetuating our current services (Prologue).

This practicum used a pre-test / post-test research design to assess behavioral and emotional changes in the children. The Child Behavior Checklist (Achenbach, 1991) and the Piers Harris Children's Self-Concept Scale (1969) were administered before and after the group program to determine if the group intervention had an effect on the children's internalizing and externalizing behaviors as well as increasing their self-concept. The implementation of the two groups will hopefully provide further evidence that child witnesses can benefit from this approach.

Definition of Terms

Several terms will be used repeatedly in this practicum report. Parental violence refers to any physical (e.g., hitting, pushing, slapping, kicking), sexual (e.g., unwanted sexual intercourse), or emotional (e.g., name-calling, negative comments) abuse that occurs between the parents (including common-law partners) of a household (Wolak & Finkelhor, 1997). Witnessing parental violence refers to being within visual range of the violent episode and seeing it occur (Edleson, 1999). Exposure to parental violence includes witnessing and or hearing the violent episode between the parents (e.g., yelling between parents, sound of objects being thrown). The child who witnesses the aftermath of the violent episode (e.g., visible scratches/bruises on the victim, seeing the father being arrested by police officers) will be included in this definition.

CHAPTER 2

Review of the Literature

Prevalence of Parental Violence

Documenting the number of children exposed to parental violence is a difficult and challenging task for researchers. The difficulty is related to a number of factors including: (a) the lack of a standard definition of the variables in question (e.g., partner violence, exposure); (b) the lack of consistency in how violence is defined (some studies only include physical abuse while other studies use a broader definition including emotional abuse); and (c) differences in the sample being investigated (some studies are based on community samples while others use shelter samples) (Carlson, 2000; Graham-Bermann & Edleson, 2001). These factors make it difficult for researchers to document the actual the number of children exposed to parental violence.

Another challenge confronting researchers is that wives and husbands often do not agree with each other about the occurrence of violence (Edleson, 1999; Graham-Bermann & Edleson, 2001; Groves, 2002). There is evidence that some parents are not accurately reporting what their children have been exposed to in the home. Jaffe, Wolfe, and Wilson (1990) found that many parents minimize the presence of children during incidents of wife assault by suggesting that the children were asleep or playing outside. However, these researchers found that a majority of these children were able to provide detailed accounts of violent behavior that their mother or father never realized they had witnessed. Similar findings were found by Zuckerman and Augustyn (1996) who reported that parents consistently underreported what their children had seen and that these children were able to provide vivid accounts of fights or assaults in the house.

Police records are used to document the prevalence of domestic violence. These records however, may underestimate the prevalence of domestic violence. Some victims may choose not to report violent incidents for various reasons including: denying the abuse in order to preserve the family unit, perpetrators' denial of abusive behavior, victims' financial or emotional dependence on the abuser, and victims' belief that police or service providers will not help or be unjust or discriminatory (especially among ethnic minority or gay and lesbian families) (Brown University, 1996). As a result, research surveys based on police records may not accurately reflect the actual number of women and children who are exposed to domestic violence.

Despite the difficulties inherent in determining the prevalence of exposure to parental violence, existing research suggests that a large number of children are exposed to this form of violence. The most widely cited estimates of the number of children who witness violence come from the work of Carlson and Strauss. Carlson (1984) estimated that 3.3 million children in the United States were exposed to parental violence annually. A more recent survey by Strauss (1992) reported that 10 million children were exposed annually to violence between their parents.

The number of children exposed to parental violence in Canada is equally alarming. Statistics Canada's General Social Survey (1999) estimated that 37% of spousal violence victims reported that children had either heard or seen at least one episode of violence (Statistics Canada, 1999). The same survey revealed that in many cases, children have resided in households where severe acts of violence have taken place and in those households where a child reportedly witnessed the violence, 41% of victims had feared for their lives at some point in the past five years (Statistics Canada, 1999).

This survey further reported that children were almost twice as likely to witness violence against mothers as against fathers (Statistics Canada, 1999). Clearly, many children in Canada witness violence between their parents and interventions are greatly needed to meet the needs of these children.

In summary, researchers are faced with many challenges in documenting the prevalence of parental violence exposure. Nevertheless, it is clear from these estimates that domestic violence is a growing social problem that affects a significant number of women and children in North America.

Harmful Effects of Parental Violence

Exposure to parental violence can be harmful to children by affecting them directly and also indirectly through the impact of the violence on their parents (Edleson, 1999). Direct effects include placing the child in physical danger. Parental violence exposure increases the risk of physical injury to children even if they are not the intended victims (Tajima, 2002). Children in close proximity may be hit by objects being thrown or hurt by weapons being used. Children attempting to stop the violence between their parents may also be accidentally hit, pushed, or shoved (Wolak & Finkelhor, 1997). There are a number of reported cases where some parents have fought over their children or have used the children as pawns during physical conflict (Peled, 1998). Other direct effects include emotional and behavioral problems that result from attempts to cope with the violence, and the learning of aggressive behavior styles (Edleson, 1999). Indirect effects come from maternal physical and psychological ill health resulting from the stress of being abused, exposure to paternal anger and irritability, and inconsistent parenting

disciplinary practices (Edleson, 1999). Groves (2002) further argues that parental violence "psychologically robs" children of both parents.

Short Term Effects

Children exposed to parental violence are at risk of developing problems in the following: behavioral (e.g., aggression, tantrums, acting out), emotional (e.g., anxiety, depression, withdrawal), and cognitive (e.g., poor academic performance, language lag) (e.g., Carlson, 2000; Edeleson, 1999; Kolbo & Blakely, 1996; Wolak & Finkelhor, 1997). Additional short-term effects of parental violence exposure include abnormal fears, regression, truancy, bullying or a tendency to become a victim, impulsiveness, and denial or obsessive retelling of the incident (Fischer, 1999). Exposure to repeated violence between parents may also trigger symptoms associated with Post Traumatic Stress Disorder including difficulty falling asleep, recurrent nightmares, and intrusive flashbacks (Fischer, 1999; Wolak & Finkelhor, 1997).

Behavioral Problems

The Child Behavior Checklist (Achenbach, 1981) has been utilized in several studies that investigated the impact of witnessing parental violence. In general, there is strong empirical evidence (e.g., Christopoulous, Cohn, Shaw, Joyce, Sullivan-Hanson, Kraft, & Emery, 1987; Copping, 1996; Moore & Pepler, 1998) that children exposed to parental violence score higher on behavioral problems (often called externalizing problems) than non-exposed children. However, there are a number of studies (e.g., Hughes, 1998; Jouriles, Barling, & O'Leary, 1987) that have not found significant

differences between exposed and non-exposed children with respect to externalizing behavior problems.

Emotional Problems

There is empirical evidence that children exposed to parental violence show higher levels of emotional problems (often called internalizing behaviors) than non-exposed children. Hughes (1988) found that children exposed to parental violence had higher levels of anxiety and lower self-esteem than non-exposed children. However, Holden and Ritchie (1991) found no significant differences in internalizing behavior problems between exposed and non-exposed children.

Cognitive Difficulties

A number of investigations have been conducted to determine if children exposed to parental violence experience more cognitive problems than non-exposed children. However, the results from these investigations are unclear and mixed. An investigation by Moore and Pepler (1998) found that parental violence exposure did not affect the academic performance of child witnesses. Christopoulos et al. (1987) also found no significant differences in IQ scores between school-age witnesses and non-witnesses. In contrast, an earlier study by Andres and Moore (1995) found that children exposed to parental violence experienced academic problems several months after the mothers had left the shelter.

In a more recent study, Huth-Bocks, Levendosky, and Semel (2001) reported that preschool children who were exposed to parental violence had poorer verbal abilities than

non-witnesses even after controlling for socio-economic status and child abuse. However these researchers found no group differences on visual-spatial abilities.

The limited amount of research in this area make it difficult to understand the impact of parental violence on children's cognitive functioning. In addition, the impact of parental violence on school performance is difficult to study because many of the characteristics of maritally violent families such as low income and homelessness are associated with poor school performance and thus must be controlled (Carlson, 2000).

Summary

In sum, empirical evidence suggests that children exposed to parental violence are at greater risk of developing behavioral and emotional problems than non-exposed children. However, inconsistent findings from several studies suggest the need for further research into the impact of parental violence on children.

Long Term Adjustment Problems

Children who continue to experience behavioral and emotional difficulties are at risk for future difficulties (e.g., juvenile delinquency, problems with interpersonal relationships, and low self-esteem). Although empirical evidence is not conclusive, there is evidence that early exposure to parental violence can have lasting effects into adulthood. Long term development problems can include depression, trauma-related symptoms, and low self esteem among women and trauma related symptoms among men (Edleson, 1999).

Long term adjustment problems are based on retrospective accounts of adults who have been exposed to parental violence as children (Edleson, 1999). These studies suggest that later physically aggressive behavior (e.g., adolescent violence, parental violence, parent-child abuse, and adult aggression toward dating partners) is associated with earlier exposure to physical abuse. Adult females exposed to parental violence are more likely to become victims of domestic violence (Edleson, 1999). One explanation for this finding is that women who have been abused are compelled to repeat the trauma of their childhood in adult relationships in order to master feelings of terror and helplessness experienced as child witnesses of relationship violence (Maker & Kemmelmeier, 1998).

Some of the research on the long-term effects of exposure to parental violence have involved college students. In one study, Silvern, Karyl, Waelde, Hodges, Starek, Heidt, and Min (1995) found that among undergraduate students, witnessing violence as children was associated with adult reports of depression, trauma-related symptoms, and low-self esteem. An investigation by Henning, Leitenberg, Coffey, Turner, and Bennett (1996) reported that adult women who had witnessed domestic violence as children showed greater distress and lower social adjustment when compared to women who were not exposed to parental violence. Maker and Kemmelmeier (1998) also studied the long-term psychological consequences in women who witnessed parental violence. These researchers found that women who witnessed parental violence experienced more violence in dating relationships, exhibited a greater number of antisocial behaviors, were more depressed, and showed a greater number of trauma symptoms than women who were not exposed to parental violence. A longitudinal study by McNeal and Amato

(1998) provides further evidence that effects of exposure to parental violence can last into adulthood. They found that parents' reports of marital violence between 1980 and 1988 (when children were between the ages of 11 and 19) predicted offsprings' reports of negative outcomes in early adulthood, including poorer parent-child relationships, lower psychological well-being, and more violence within their own relationships.

In sum, retrospective studies suggest that children exposed to parental violence are at greater risk of developing future difficulties. However, the link between childhood exposure and future problems has not been clearly established and requires further investigation to determine the unique impact of witnessing parental violence. The results from these studies must be interpreted with caution. Fisher (1991) points out that not all children who have been exposed to parental violence will become perpetrators and that most will not abuse their own offspring. Similarly, Jaffe et al. (1990) have noted that many children in their studies showed few negative symptoms from exposure to parental violence. According to these investigators, some children showed higher social competence than comparison children. These children have been described as "resilient children"—children who have been able to adapt despite their exposure to stressful and high risk environments (Hughes, Graham-Bermann, & Gruber, 2001).

Resilience in Children Exposed to Parental Violence

Resiliency in children has been an area of interest for researchers for over 20 years (Hughes et al, 2001). The existing knowledge on resilient children comes from studies that investigated children who were living in stressful environments. Studies in the past have focused on: children of divorce (Hetherington, Bridges, & Isabella, 1998),

children born prematurely or with low birthweight (Werner, 1989), children living in poverty (Elder, 1974), and children living in foster care (Folman, 1995). To date, there have been no studies that investigated resiliency in children exposed to parental violence.

There appears to be some debate over how resiliency should be defined. More specifically, there is disagreement with the following (Hughes et al., 2001):

- Whether resiliency should be developmental or culturally defined.
- Whether resiliency should be viewed as general (i.e., general lack of obvious symptoms) or domain specific (affecting conduct, social competence, or academic achievement).
- The number of domains unaffected in order for the child to be defined as resilient.
- The length of time the child remains symptom-free in order for the child to be considered truly resilient.

In sum, the lack of a standard definition of resiliency makes it difficult for researchers to study this area. Additional research is required to understand how some children exposed to parental violence are able to overcome their stressful situations.

Moderating and Mediating Factors

The literature makes a distinction between moderating and mediating factors. Moderators are factors that may influence the strength or direction of the relationship between a predictor variable (e.g. parental violence exposure) and outcome variables (Carlson, 2000). Moderating factors include characteristics of the child (e.g., age,

gender, and developmental level), severity of the abuse, time since the violent episode, whether the child was a witness but not a direct victim, and the presence of protective factors (Edleson, 1999; Fischer, 1991; Purvis 1995; Wolak & Finkelhor; 1997; Wolfe & Korsch, 1994).

A number of studies suggest that younger children (e.g., infants, toddlers, and preschoolers) exposed to parental violence are the most vulnerable due to their limited cognitive and verbal functioning. Hughes, (1988) found that preschoolers had more behavioral problems than school-age children. In contrast, Holden and Ritchie (1991) found that younger children exposed to parental violence had fewer problems than older children.

Investigations have also been conducted to determine if males and females respond differently to parental violence exposure. In general, studies suggest that males are more likely to exhibit externalizing behavior problems whereas females are more likely to exhibit internalizing problems. There are, however, several studies that have found the opposite. Davis and Carlson (1987) and Lemmey et al. (2001) found that females showed more externalizing behavior problems than males. Other studies (e.g., Kerig, 1989; Sparaccarelli, Sandier, & Roosa, 1994) found no significant differences in behavioral problems between males and females.

The severity of the abuse witnessed can also influence how children respond to parental violence. In general, most studies suggest that the more intense, the more long lasting the abuse, and more recent the abuse witnessed, the higher distress in children (Carlson, 2000). An investigation by Lemmey et al. (2001) further found that increasing

physical violence experienced by the mother was associated with increasing internalizing behavioral problems in the child.

A number of researchers (e.g., Davis & Carlson, 1987; Hughes, 1988) studied children who have been direct victims and witnessed parental violence ("double whammy"). These researchers found that witnessing and experiencing direct violence exerts a more negative impact than witnessing the violence or being abused.

Protective factors can also moderate the impact of parental violence exposure. Children who appear to be unaffected by what they have witnessed possess protective factors that buffer them against the harmful impact of parental violence. These factors can include strong family and extended family support, support from peers and teachers, and success in school and athletics (Wolak & Finkelhor, 1997).

In contrast, mediators are variables that explain the relationship between a predictor variable (e.g., exposure to parental violence) and its effects (Carlson, 2000). Baron and Kenny (1986) describe mediators as "as variables that speak to how or why such effects occur" (p. 1176). Mediators can include coping strategies employed, disrupted parenting, and PTSD (Carlson, 2000).

A number of researchers investigated the coping styles of children exposed to parental violence. Falasca (1999), Peled (1998), and Wolak and Finkelhor (1997) found that some children cope with parental violence by using one or a combination of the following strategies: physically distancing themselves from the violent episode--"problem focused" (e.g., leaving the scene once fights had started), dissociation/detachment--"emotion focused" (e.g., using distractions and or "tuning-out" the violence), and interference (Falasca, 1999; Folkman & Lazarus, 1984; Peled, 1998).

Motivations for interfering in the violent conflict can include: (a) showing support of or opposition to, one of the parents; (b) protecting the abused parent or preventing harm when the situation looked dangerous; and (c) alleviating feelings of anxiety, distress, and helplessness (Peled, 1998).

Some children cope by attempting to de-emphasize their father's violence by (a) seeing the father as ill whose violent behavior is due to this illness; (b) attributing the father's abusive behavior to some other factor (e.g., alcohol or drugs); and (c) forgetting the abuse as a way to protect themselves from further emotional harm (Peled, 1998).

Coping strategies employed can also create additional problems for children who are attempting to cope with the violence at home. Some children may run away from home or turn to drugs and alcohol as a way of coping with the stress created by parental violence (Wolak & Finkelhor, 1997). Other children may feel embarrassed and attempt to conceal the "family secret" by isolating themselves from peers (Wolak & Finkelhor, 1997). This coping strategy may cause difficulties in their interpersonal relationships.

Disrupted parenting is another mediating variable that has been discussed in the family violence literature. Studies have documented the emotional and stress related effects of domestic violence on women including symptoms of Post Traumatic Stress Disorder (PTSD), depression, anxiety, and other physical health effects (Carlson, 2000). In addition, the mother's preoccupation with her own safety may interfere with her ability to be an effective parent. The mother who has been abused may not have the physical and emotional capacity to help her children deal with the violence at home. Levendosky (2000) studied a group of mothers' perceptions of the effects of domestic violence on their parenting. She found that most of the mothers reported that domestic violence had

negatively effected their parenting (e.g., reduced amount of time and energy for their children, less motivated to be involved in their children's social and emotional development, and tended to blame their children for their problems).

Summary

Moderating and mediating factors can influence the way child witnesses respond to parental violence. The literature suggests that how children respond to parental violence varies from one child to another and that each child is uniquely different. One child who witnesses his father physically and verbally abuse his mother may exhibit emotional and behavioral difficulties from the experience while another child may seem relatively unaffected by the incident. Clearly, additional research is required to understand the long-term effects of parental violence on children.

Theoretical Models

Several theoretical models have emerged in the literature that attempt to explain how child witnesses are impacted by parental violence. This practicum report discusses social learning theory, parental violence as trauma, a risk and protective factors model, and attachment theory. These theories have received significant attention in the field of domestic violence.

Social Learning Theory

The premise of social learning theory is that behavior is learned by observing the behavior of others and imitating the behavior in other situations. Bandura (1977) proposed that observational learning includes the following four steps:

(1) Focusing on the important aspects of the behavior

(2) Storing the observed behavior in memory

(3) Converting the remembered observation into action

(4) Being motivated to adopt the behavior

Social learning theorists argue that role models significantly influence children's behavior. From this perspective, children learn aggressive problem-solving tactics from violent role models. Children who witness violence between their parents acquire information regarding the emotional triggers for the violence, circumstances of violence, and the consequences of violence (Foshee, Bauman, & Linder, 1999). Children are more likely to imitate the behavior if positive consequences are associated with the behavior and are less likely to imitate the behavior that is associated with negative consequences (Foshee et al., 1999; McAlister-Groves, 2002).

Children who witness parental violence learn that violent and aggressive tactics can be an effective means to control others (Foshee et al., 1999). A child who witnesses his father hitting his mother may observe the deference and fear shown by the mother toward the father. Social learning theorists argue that children who are continually exposed to parental violence will use similar tactics in their own relationships. These theorists further argue that children who witness parental violence lack exposure to

individuals who can model more appropriate ways of resolving conflict (e.g., verbal reasoning, self-calming strategies). These children will reach adulthood and continue to use violent tactics.

There is empirical support for social learning theory. Foshee et al. (1999) studied adolescent dating violence and used data from 1, 965 eight and ninth graders. These researchers found that exposure to family violence was positively associated with dating violence. Furthermore, they found that for both genders, this relationship was mediated by "social-learning-theory-derived variables of acceptance of dating violence and aggressive conflict-response style" (p. 331).

Two criticisms have been raised against social learning theory. One criticism is that the theory fails to explain why the majority of children exposed to parental violence do not imitate the behavior of violent role models. Kolbo and Blakely (1996) argue that a "linear social learning model" cannot fully explain the relationship between children's witnessing domestic violence and their subsequent development. These researchers point out that more attention is needed on the variables that might mediate this relationship.

Social learning theory fails to explain how other problems develop in children including post-traumatic stress symptoms, low self esteem, and interpersonal difficulties (Carlson, 2000). Dutton (1996) adds that the theory does not explain how certain internal events are acquired including dysphoric states (e.g., depression, chronic anger), attributional styles (blaming of victim), defensive strategies (e.g., projection), and insecure attachments.

One variant of social learning theory is the Intergenerational Transmission of Violence (IGTV) hypothesis. This framework refers to the perpetuation of domestic

violence from one generation to the next (Graham-Bermann & Edleson, 2001; Johnson & Ferraro, 2000; McNeal & Amato, 1998; O'Neill, 1998). According to this perspective, children raised in violent homes are more likely to become perpetrators or victims of partner violence than children raised in nonviolent homes where aggressive or victimizing family patterns are passed on from parent to child (Wolak & Finkelhor, 1997). O'Neill (1998) describes IGTV as a process that operates like a hereditary disease with each new generation passing it on to the next. Through the process of observational learning, children learn that violence is an effective means of problem solving and will continue to use similar tactics in their own relationships.

IGTV is supported by empirical evidence. As previously stated, retrospective studies (e.g., Silvern et al., 1995, Henning et al., 1996) of college students provide evidence that early exposure to parental violence can last into adulthood. However, there is also evidence (e.g., Fisher, 1991; Jaffe et al., 1990) that not all children are negatively effected by parental violence.

In sum, social learning theory is useful for explaining how children learn to behave in various situations. However, this theory does not adequately explain why not all children will imitate what they have witnessed. Furthermore, the theory does not explain how some children develop internal difficulties.

Parental Violence as Trauma

According to Falasca (1999), trauma is an "event or a series of events that renders the individual helpless and breaks through ordinary coping strategies or both" (p. 212). Graham-Bermann and Levendosky (1998) assert that trauma occurs when an event elicits

fear, helplessness, and over-stimulation and when that event is identified by the observer as traumatic (p. 111). Repeated exposure to parental violence can lead to symptoms associated with PTSD (Falasca, 1999).

The 4th version of the Diagnostic Statistical Manual (DSM-IV) is adult-focused and does not include PTSD criteria for children. However, based on studies involving adults diagnosed with PSTD, a number of researchers argue that some children exposed to parental violence show similar symptoms.

A PTSD diagnosis groups symptoms into three areas including re-experiencing (e.g., intrusive memory, nightmares, unwanted remembering), avoidance (e.g., repression of thoughts related to the violence, avoidance of activities reminiscent of the trauma, flat or little affect), and hyper-arousal (e.g., sleep problems, irritability, difficulty concentrating, hypervigilance) (American Psychiatric Association, 1994). PTSD is also categorized as acute or chronic. An acute PTSD diagnosis requires that the symptoms persist for one month but less than three months (American Psychiatric Association, 1994). Symptoms that persist for three months or longer are considered as Chronic PTSD (American Psychiatric Association, 1994). Trauma theorists argue that PTSD leads to a dysregulation in neurotransmitter output (Rossman, 2001).

PTSD is viewed in the literature as the body's way of protecting itself from threat or danger. This defense mechanism triggers the body to prepare itself for a fight or flight response. Several neurobiological changes within the body take place. In a study of Viet-Nam veterans diagnosed with chronic PTSD, Van der Kolk (1996) reported an increase in the output of neurotransmitters (adrenaline and non adrenaline), and glutocoids (cortisol, dopamine, endenous opiates) and a decrease in serotonin. Trauma

theorists argue that this dysregulation in neurotransmitter activity underlie the behavioral symptoms of PTSD including difficulties with attention, concentration, and memory consolidation; greater irritability; exaggerated startle; and greater fluctuation in mood (Graham-Bermann & Edleson, 2001). The behavioral problems exhibited by children exposed to parental violence are hypothesized to be related to these neurobiological changes that are triggered by PTSD.

Trauma theorists further argue that parental violence can change children's cognitive processing abilities. A number of studies have shown that children exposed to parental violence experience more cognitive difficulties than non-exposed peers (Rossman, 2001). One explanation is that prolonged and repeated exposure to trauma can impact how children take in and use information. Research has been carried out mainly on physically and sexually abused children. However, this research may be informative for understanding how child witnesses are impacted in terms of their perception, attention, and cognition.

A number of studies suggest that children exposed to parental violence may experience attention difficulties. Medina and Margolin (1998) compared the attentional capacities of exposed children with non-exposed children. These researchers found that exposed children had poorer attentional performance than non-exposed children. Poor attention span has implications on school performance. Children exposed to parental violence may have greater difficulty focusing on school assignments and consequently, their ability to function in school will be impaired.

There is empirical evidence that exposure to parental violence can lead to PTSD related symptoms in children. Graham-Bermann and Levendosky (1998) studied the

effects of parental violence exposure on children and found that 13% of the children qualified for a full diagnosis of PTSD, many exhibited traumatic distress symptoms, and 42% experienced traumatic arousal symptoms. In a more recent investigation, Levendosky, Huth-Bocks, Semel, and Shapiro (2002) investigated the trauma symptoms in preschool age children exposed to parental violence and concluded that younger children are more vulnerable to symptoms of re-experiencing the trauma and hyper-arousal. However, these researchers point out that only a few of the children in their study showed symptoms of full diagnosis of PTSD. They argue that children respond differently to traumatic events than adults due to their lesser cognitive and emotional capacities.

In sum, parental violence is viewed from this perspective as a traumatic event that leads to a dysregulation in the output of neurotransmitters which in turn may be related to the behavioral difficulties found in exposed children. In addition, chronic exposure to parental violence may change how children take in and process information. This can lead to greater likelihood of experiencing academic problems.

A Risk and Protective Factors Model

The impact of parental violence on children can also be understood using a risk and protective factors model. Osofsky (2003) argues that this model is a useful framework for understanding children's exposure to parental violence as a risk factor for future developmental problems. This model proposes that risks and protective factors interact and shape how a child responds to parental violence.

A similar model is termed the developmental psychopathology framework (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). This framework views parental violence exposure as a risk factor that is part of a group of harm-producing contextual factors (e.g., mental health problems, child abuse, divorce, poverty, and general family dysfunction) that can lead to negative developmental outcomes for the child (Wolfe et al., 2003).

The developmental psychopathology framework emphasizes the role of developmental processes, context, and influence of multiple and interacting events (Wolfe et al., 2003). In addition, this framework considers the role of the family, social, and cultural factors that influence the child's overall development. Negative developmental outcomes (e.g., frustration, hostility, fear) represent the child's efforts to adapt to a maladaptive situation (Wolfe et al., 2003).

The developmental psychopathology framework adopts a multi-dimensional interactive approach. According to Wolfe et al., (2003):

> There is rarely a direct causal pathway leading to a particular outcome; instead, there are ongoing interactions between protective and vulnerability factors within the child, between the child and his or her surroundings, and among particular risk factors. These factors are processes rather than absolutes, since the same event or condition can function as either a protective or a vulnerability factor depending on the overall context in which it occurs. (p. 172)

The risk and protective factors model has gained significant attention in the family violence literature. This model is useful for a number of reasons. Unlike other models that emphasize a linear cause and effect explanation for the impact of parental

violence exposure on children, this model adopts a broader view of the processes involved, and considers the interplay of risks and protective factors.

Adopting a risk and protective factors model also contributes to effective prevention and intervention programs. Prevention programs can focus on finding ways to combat risk factors (e.g., poverty, maternal stress) that contribute to general family dysfunction. Child witnesses who appear to be unaffected by parental violence exposure posses protective factors (e.g., support from peers and teachers, strong family and extended family support). With this knowledge, intervention programs can explore ways to foster protective factors that can buffer children from the harmful impact of parental violence (e.g., coping styles of resilient children).

In sum, a broader view of the forces at work in shaping children's response to parental violence is more useful than a cause and effect explanation. The risk and protective factors model is a useful explanation for the impact of parental violence exposure on children. This perspective can make prevention and intervention programs more effective for children exposed to parental violence.

Attachment Theory

The effects of domestic abuse on women has been well documented in the literature. Studies on battered women suggest that they can suffer from depression, anxiety, PTSD, and a wide variety of physical health effects (Carlson, 2000). These factors can impact on the women's ability to function as effective parents. Consequently, the child's attachment to his or her mother may weaken.

Bowlby's (1973) attachment theory has been used to understand the development of attachment in individuals. This theory proposes that attachment is formed during infancy when the mother and child engage in caregiving and attachment behaviors. When the mother is not in close proximity, the attention system is activated (e.g., crying) and the infant experiences separation anxiety until the mother returns.

The development of an individual's internal working model is another aspect of attachment theory (Bowlby, 1973). Early positive experiences with a caregiver, usually the mother, will help to shape the child's internal working model. This relationship will help the child to develop expectations about others' roles in later interactions and form expectations about themselves and their role in these relationships. Flaherty and Ricchman (1985) state, "These early experiences become internalized, and create anticipatory images that shape attitudes and reactions to, and perceptions of, individuals later encountered" (p. 427). In applying this theory, an argument can be made that parental violence can impact the child's internal working model. Furthermore, parental violence exposure can weaken the mother-child attachment. The mother who is pre-occupied with her own safety may not be emotionally available for the child who is seeking nurturance and comfort (attachment behavior).

The major criticism of attachment theory is that it commits mother-blaming (Eyer, 1996). According to this theory, mothers play a critical role in the formation of attachment with their children. Mothers are viewed as responsible for problems in their relationship with their children. Another criticism of attachment theory is that it does not take into account the influence of other factors that can impact how children form attachments with other individuals (Eyer, 1996).

Researchers investigated the impact of parental violence on the mother-child relationship during the early stages of the child's development. Wolfe and Korsch (1994) have noted that parental violence can weaken an infant's attachment to his or her mother by disrupting normal routines around sleep time and feeding. Furthermore, the mother who is living in constant fear of her partner may be unable to handle the stressful demands of an infant. This disruption can affect the development of the child's sense of self and capacity to form and maintain future relationships (Purvis, 1995).

Partner abuse is often accompanied by additional burdens. Wolak and Finkelhor (1997) assert that in addition to living in constant fear of being abused, the mother is confronted with "mulitple stressors" (e.g., stresses from divorce, financial difficulties, unemployment, homelessness). These factors can interfere with her ability to help her child cope with his or her distress. Carlson (2000) describes the impact of domestic violence on parenting stress: "Marital conflict is a stressor that causes parents to become irritable, depressed, distracted, and emotionally drained and reduces parents' attentiveness and prosocial responsiveness to their children" (p. 332).

There is empirical evidence that domestic violence can negatively affect the parenting of battered mothers. These studies suggest that psychological and physical abuse of women by their partners affects parenting stress and parenting behaviors (Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998).

Anecdotal evidence also provides support that domestic violence can add to parenting stress. Levendosky (2000) studied mother's perceptions of the effects of domestic violence on their parenting. Most of the women reported that their parenting was negatively affected by their partner's violence. Several women in this study cited the

following negative effects domestic violence had on their parenting: reduced amount of time and energy for their children, reduced motivation to be involved in their children's social and emotional development, and experienced an increase in anger toward their children (transference). A number of the women in this study also reported several positive changes that resulted from experiencing abuse. Several women reported that abuse from their partners had increased their sensitivity and empathy for their children. Some of the women reported that negative strategies (e.g., attacking their child's self-image) were avoided. It seemed that their own experience with domestic violence heightened their own awareness of its negative effects. In addition, several mothers in this study reported being more protective of their children. This study suggests that some of the women were actively attempting to protect their children from the harmful effects of domestic violence rather than passively accepting the violence from their partners.

Summary

The theories reviewed in this practicum report are useful for understanding how children exposed to parental violence are impacted. Social learning suggests that behavior is learned by observing others and whether or not the behavior is imitated depends on the positive or the negative consequences that go along with it. Viewing parental violence as trauma is also useful; trauma theory provides a possible explanation for the externalizing and internalizing behaviors that result from witnessing parental violence. A risk and protective factors model also provides a useful explanation for the impact of parental violence exposure on children and can enhance the effectiveness of prevention and intervention programs. Finally, attachment theory is a sound explanation

for understanding the development of the mother-child relationship. The theme that appears to emerge in reviewing these theories is that a single theory cannot fully explain how children are impacted by the violence they witness between their parents. The theories reviewed all contribute to our understanding of the impact of parental violence on children.

Research Challenges

Limitations in Research

The number of investigations on the harmful effects of parental violence on children has flourished since the 1980's. However, the literature suggests that most studies have significant limitations. Some studies for example, fail to distinguish children who have experienced child abuse from children who have witnessed parental violence (Graham-Bermann & Edleson, 2001). As previously mentioned, research has shown that children who have been a direct victim and who have witnessed parental violence are significantly more affected than children who have only witnessed parental violence.

Sources of information can also create difficulties for researchers. Retrospective reports of adults exposed to parental violence as children may be inaccurate due to memory loss or distortions. A number of studies have also shown that some parents may not be accurately reporting what their children have witnessed at home (Jaffe, Wilson, & Wolfe, 1990; Zuckerman & Augustyn, 1996).

Studies that rely on shelter-based samples may also be problematic. Some studies report that children who live in shelters exhibit more externalizing behavior problems

than community samples. This is not surprising given that these children are living in transition. However, the increase in externalizing problems may be related to the stress of living in a temporary home rather than exposure to parental violence (Graham-Bermann & Levendosky, 1998; Lemmey et al., 2001; Levendosky et al., 2002). Therefore, the results from shelter-based studies cannot be generalized to children exposed to parental violence and who are not living in shelter (Carlson, 2000).

Additional limitations that are mentioned in the literature include an overreliance on the Child Behavior Check List (Achenbach, 1981) (the measure does not specifically tap into which difficulties are related to witnessing parental violence), lack of longitudinal studies, problems with definitions, and limited number of studies on the relationship of the child with the perpetrator (Carlson, 2000; Geffner, Jaffe, & Sudermann, 2000; Graham-Bermman & Edleson, 2001).

Implications for Research

Several recommendations have emerged from the domestic violence literature. Firstly, accurate information regarding the number of children who witness parental violence is needed. This is important for three reasons: (a) to convince policy makers that domestic violence and its impact is a social problem that requires attention; (b) once policy makers are convinced that the domestic violence is a social problem, then resources can be allocated to tackle the problem; and (c) knowing how many people are affected by domestic violence can help to inform the development of cost effective and targeted interventions (Graham-Bermann & Edleson, 2001). Zuckerman and Augustyn (1996) recommend tabulating police reports of domestic violence. This suggestion

however ignores the fact that many incidents of domestic violence go unreported to the police for the reasons already mentioned. Utilizing multiple sources of information regarding both children's functioning and the nature of the violence within the family (e.g., child, siblings, teachers) can also provide researchers with a more accurate picture of the impact of parental violence on children (Kolbo & Blakely, 1996).

Secondly, additional longitudinal studies are needed to learn more about the long-term effects of parental violence. There have been a limited number of longitudinal studies that have been conducted in the last twenty years. More longitudinal research using representative samples would be useful.

Thirdly, additional research on resilient children is required. The majority of resiliency studies have focused on children facing adversities (e.g., poverty, low birth weight, children living in foster care, and children of divorce). However, to date, there have been no investigations on the resiliency of children exposed to parental violence (Graham-Bermann & Edleson, 2001). Many unanswered questions remain: Do resilient children use different coping styles? How are coping strategies developed? Are there gender differences with the use of coping strategies? As previously mentioned, several researchers (e.g. Fischer, 1999; Jaffe et al., 1990) point out that many children who have been exposed to parental violence show few negative symptoms. Studying how resilient children are able to overcome the effects of parental violence is important because this will contribute to our understanding of how to support children and facilitate positive outcomes.

Fourthly, additional research is required on child witnesses who are not living in a shelter (Graham-Bermann & Edleson, 2001). As previously mentioned, children who are

exposed to parental violence and are living in a shelter show higher levels of externalizing problems than community samples. This difference may have more to do with living in transition and other stresses (e.g., being away from father). Additional research on child witnesses not living in a shelter would enhance the generalizability of family violence studies.

Finally, Peled (2001) recommends the need to conduct "ethically sound research" and proposes five guiding principles. In her view, ethical research: (a) is an important part of the research process (researchers are mindful of ethical standards while doing research), (b) is relational undertaking (respect for the participants), (c) should empower the participants involved (provide useful information to participants), (d) should respect children, and (e) should benefit the participants involved and should not harm the participants in any way.

In sum, research on the effects of witnessing parental violence is increasing. However, the need for additional research is evident. More accurate instruments are needed and multiple sources of information should also be utilized. Furthermore, studies that investigate the effects of parental violence exposure should also be ethically sound, as suggested by Peled (2001). Researchers must treat individuals as "working partners" rather than "subjects" in their quest to learn more about the effects of witnessing parental violence.

Group Work with Children Exposed to Parental Violence

Treatment approaches for children exposed to parental violence have generally focused on individual therapy, a family systems approach, and a group approach (Edleson, 1999; Wagar & Rodway, 1995). Group work with children has been used to

address a variety of issues including divorce, social skills, academic achievement, family alcoholism, and chemical dependency (Garrett & Crutchfield, 1997; Rose, 1998). Group work can be an effective treatment for children exposed to parental violence.

A group work approach is contraindicated for children who have been exposed to severe forms of parental violence and who display more extreme adjustment problems (Wagar & Rodway, 1995). Children who are in complete denial about the presence of violence in the home are likely not good candidates for group as well (Loosely, 1997). Nisivoccia and Lynn (1995) point out that children who are too psychotic and who retreat into total fantasy and / or act aggressively may frighten other children and will not benefit from a group work intervention. Individual therapy is recommended for these children (Nisivoccia & Lynn, 1995).

Development of Children's Groups

Canada

Children's groups in Canada stem from the research conducted by Peter Jaffe, Executive Director of the London Family Court Clinic. Jaffe et al. (1986) investigated the effects of domestic violence on women and children and the benefits of utilizing a group work approach. Their work led to the development of a group work manual that was subsequently revised by Wilson, Cameron, and Wolfe (1989).

The Wilson et al. (1989) manual outlines a 10-week intervention model for children between the ages of 8 and 13 years who were exposed to parental violence. Groups are subdivided at ages 10 or 11 years and consist of 10 participants in each group. Groups are facilitated by a male/female co-therapy team. The goals of this program

include assisting children to develop adaptive responses to experiences they have already encountered, helping children to develop appropriate strategies for conflict resolution, examining the use of violence as an ineffective method for problem solving, and developing self-esteem (Wilson et al., 1989).

Topics for discussion include the importance of confidentiality; naming and understanding different kinds of feelings; dealing with anger in an appropriate manner; safety skills; the importance of social support and who to turn to for emergency; self-concept and social competence; responsibility for the violence; myths around family violence; family issues (e.g., separation, new partners in their parents' lives, conflicting, loyalties); and review and termination (Wilson et al., 1989).

Several agencies in Ontario, Canada adopted the Wilson et al.(1989) intervention model including Madame Vanier Children's Services, the Children's Mental Health Centre, and London Children's Aid Society. This led to the development of the Community Group Treatment Program for Child Witnesses of Woman Abuse.

United States

Much of the development of children's groups in the U.S. took place in Minneapolis, Minnesota (Mullender & Morley, 1994). The Domestic Abuse Project (DAP) was established in 1979 and offered a variety of services including support groups for men and women, open ended self-help groups, individual counselling, couple and family work after the violence has ended, and advocacy with police and courts as wells as children's groups (Mullender & Morley, 1994). The DAP is based on a 10-week

curriculum for age-specific groups. The DAP led to the development of a group work manual by Peled and Davis (1995).

Rationale for a Group Work Approach

As previously mentioned, social learning theory proposes that children can learn aggressive behavior by observing the behavior of violent role models and are more likely to imitate the behavior if there are few negative consequences for this behavior (Bandura, 1977). Jaffe et al. (1986) assert that children are also likely to learn the following lessons from violent parents: (a) violence is an appropriate form of conflict resolution; (b) violence has a place within the family interaction; (c) if violence is reported to others in the community, including mental health and criminal justice professionals, there are few, if any, consequences; (d) sexism, as defined by an inequality of power, decision making, and roles within a family is to be encouraged; (e) violence is an appropriate means of stress management; and (f) victims of violence are to tolerate this behavior at best, and to examine their responsibility in bringing on the violence, at worse. Jaffe et al., (1986) argue that positive role models can teach children alternative ways to resolve conflicts.

As previously stated, a growing body of research indicates that children exposed to parental violence are at greater risk of developing behavioral, emotional, and social problems than non-exposed peers. The literature further suggests that children will learn to accept violence as an appropriate strategy for conflict resolution (Jaffe et al., 1986). Given the potential that children will learn these lessons from violent role models, it seems logical that interventions that prevent future violence should be a high priority while children are still young (Sudermann, Marshall, & Loosely, 2000).

Children can benefit from a group work approach in several ways. Through the mutual sharing of experiences, the group experience can help members feel less isolated and have their feelings validated (De Lucia & Janice, 2000; Peled & Davis, 1995; Wagar & Rodway, 1995, Wilson et al., 1989). Children can learn that the group can be a safe place to talk about the violence they have seen between their parents. De Lucia and Janice (2000) add that the group experience can help children to grow:

> Group work and programmed activities can provide a nurturing environment for children while giving them opportunities to have corrective emotional experiences and to increase their interpersonal skills. The use of groups builds on the strengths of the children and helps move them beyond the experiences they have witnessed. Interventions include helping the children learn mutual aid processes, thereby increasing their social networks. (p. 25)

Theme-oriented activities can educate children that violent and aggressive tactics can be replaced with more positive and appropriate forms of conflict resolution. The use of educational videos, role-playing, and books dealing with conflict management can teach children alternative ways of resolving conflict. In addition, the group experience can: improve self-esteem, promote wellness, reduce aggression, promote violence-related vocabulary, increase feelings of support, offer effective ways to cope with the feelings that are generated, and allow members to experience cohesiveness and mutual aid (Falasca, 1999; Garrett & Crutchfield, 1997; Nisivoccia & Lynn, 1995; Peled, 1998; Peled & Davis, 1995). De Lucia and Janice (2000) state that from an economic standpoint, more children receive services if group interventions are used.

A group work approach appears to be the most frequently employed intervention for child witnesses because it allows them to talk about their experiences with their peer group (assists in learning and breaking the silence associated with family violence); the group format is similar to activities children are familiar with in the community/school; and children can learn about family violence in a safe environment (Sudermann et al., 2000). In addition, group work can be used to address issues that children experience as a result of exposure to parental violence. These include externalizing problems (e.g., aggression), internalizing problems (e.g., worrying and trauma symptoms), and social problems (rejection by peers, expectations about males and females) (Sudermann et al., 2000).

Conditions Conducive to Group Work

Children are more likely to benefit from a group work approach when the violence between their parents has stopped. The child who continues to witness violence in the home will not feel safe and thus not benefit fully from the group experience (Stephens, 1999; Wolfe & Korsch, 1994). Wolfe and Korsch (1994) note that children who continue to feel unsafe in their home will not be able to focus on loftier goals such as social development and academic commitment (Wolfe & Korsch, 1994).

Children will also benefit from the group experience if they feel safe within the group (Peled & Davis, 1995; Rose, 1998; Wilson et al., 1989). Group leaders can create a healthy working environment by fostering a sense of trust and rapport with the children, promoting respect among group members, establishing ground rules, discussing issues

around confidentiality, and paying close attention to the room's setting (Peled & Davis, 1995; Toseland & Rivas, 1998; Wilson et al., 1989).

The therapeutic value of group work is enhanced when parents are receiving some form of treatment. Wagar and Rodway (1995) assert that the effectiveness of a group program increases when parents are receiving treatment (individual or group) concurrently with the children in order that the learning that has taken place will not be undermined in the family environment. One study found that children's use of specialized domestic violence services may depend a great deal on their mothers' own participation in services and, to a degree, also on their fathers' participation (Peled & Edleson, 1998).

In addition, several factors must be considered prior to facilitating a children's group. Group facilitators must consider: group composition, the pre-screening interview, co-leadership, and group activities to be utilized.

Group Composition and Duration of Groups

Special consideration should be given to group composition including chronological age of each child, developmental stage of the child, and size of the group (Loosely, 1997; Toseland & Rivas, 1998; Wickham, 1993). The literature suggests that similar chronological age and developmental level is helpful but not essential (Evans & Shaw, 1993; Loosely, 1997). A gender-balanced group has also been found to be important with older children (pre-teens and teens) and less important with younger children (Sudermann, et al., 2000). It is generally recommended that the group be comprised of 6 to 9 children (Loosely, 1997; Nisivoccia & Lynn, 1995; Rose, 1998;

Wilson et. al, 1989). The duration of groups varies from group to group. However, short-term groups generally last approximately 8 to 10 weeks with each session lasting 1 to 1.5 hours (Loosely, 1997; Wilson et al, 1989).

Co-Leadership

It is generally recommended that groups be facilitated by two individuals. The benefits of co-leadership are: group leaders can share responsibilities for the treatment process; group leaders can receive and provide emotional support; group leaders can help each other in setting limits and structuring the group experience; and group leaders have a source of feedback (Loosely, 1997; Peled & Davis, 1995; Toseland & Rivas, 1998; Wickham, 1993; Wilson et al., 1989).

Male and female co-leadership is also recommended when working with children exposed to parental violence (Loosely, 1997; Wickham, 1993; Wilson et al., 1989). Inclusion of both genders provides the children with positive role models for appropriate male-female interaction (Loosely, 1997; Wilson et al., 1989).

There are, however, several disadvantages to having two group facilitators. According to Toseland and Rivas (1998), co-leadership can be expensive and time consuming. Conflicts may also arise between an experienced and an inexperienced leader. A "mismatch" between leaders can impact upon group members as Wickham (1993) notes: "Conflicts, competition, and power struggles may be imposed on a group to the detriment of the members and the treatment process" (p. 118). Group leaders must therefore consider the advantages and disadvantages of co-leadership prior to the start of the group.

Rationale for Incorporating Play in Group Work

An important component in group work is the use of play. According to Axline (1947), "Play is the child's natural medium of self-expression" (p. 9). The use of play in group work can help the child feel comfortable and safe in his or her environment. Furthermore, observing the child's play can provide group leaders with vital information including the child's emotional and social development as well the nature of the child's unpleasant experiences (Lubiniv, 1994).

Group Activities

Several researchers (e.g., Nisivoccia & Lynn, 1995; Wilson et al., 1989) have noted the importance of using theme-oriented group activities with children exposed to parental violence. Group activities can include arts and crafts, board games, puppet shows, role-plays, educational videos, and story-telling (Falasca, 1999; Nisivoccia & Lynn, 1995; Rose, 1998). According to Falasca (1999), story-telling is a "trauma-focused activity" that can assist the child to "transform recent and traumatic memories from the morbid and grotesque into a more ordinary part of everyday life" (p. 4). Rose (1998) also describes the therapeutic value of story telling:

> Stories are useful in developing the interpersonal-cognitive problem solving skills of children. Stories give children the opportunity to think of common social situations involving other children. Children are able to relate to conflicts, dilemmas, and emotional distressing events from a comfortable distance and gingerly to think of them and apply them to their own lives" (pp. 47-48).

Responsibility for the violence is discussed in most groups for child witnesses (Peled & Davis, 1995; Wagar & Rodway, 1995; Wilson et al., 1989). This issue can be addressed using direct methods (e.g., telling the children that the violence was not their fault) or indirect methods (e.g., chants or songs that repeatedly includes the phrase "It's not my fault") using activities that reinforce this message to the children (Grusznski & Brink, 1988).

Snack

The provision of snack is recommended when working with children's groups. Snack serves several purposes including: it satisfies hunger pains, it is nurturing, it contributes to the children's positive and fun experience in the group, it gives children the opportunity to break from the program and practice social skills, and it provides an opportunity for modeling egalitarian gender roles when both male and female group leaders prepare and serve the food (Loosely, 1997; Peled & Davis; 1995, Rose; 1998).

Effectiveness of a Group Work Approach

Effectiveness of a group work intervention for children exposed to parental violence is supported by anecdotal and empirical evidence. Peled and Davis (1995) found that children aged 7 to 12 years were able to define abuse and distinguish among forms of abuse at the end of a 12-session group treatment program. Wagar and Rodway (1995) reported that group leaders, teachers, and primary therapists noted changes with several children who participated in a time-limited group treatment program developed by Jaffe et al. (1986). These changes were noted in the following: (a) increased self confidence, (b) the ability to protect self and knowledge of rights and support systems, (c)

increased expression of feelings, (d) increased friendship network, and (e) saying "no" to unhealthy situations (Wagar & Rodway, 1995). Loosely (1997) found that children and their mothers who participated in a parent-child group evaluated their group experience positively.

Several empirical studies also provide evidence for the effectiveness of a group work intervention with children exposed to parental violence. A study by Jaffe et al. (1986) reported changes in children in the areas of safety skill development and an increase in positive perception toward their parents following participation in group. A subsequent study by Grusznski and Brink (1988) found improvement in children's safety planning following a group intervention. Furthermore, the researchers reported that children were able to improve their self-concept, understand that the violence in the home was not their fault, and learn new ways of resolving conflict without resorting to violence.

A rigorous research design utilized by Wagar and Rodway (1995) provides additional empirical support for the effectiveness of a group work intervention for child witnesses. This study used an experimental / control group design to evaluate Jaffe et al.'s (1986) 10-week group treatment program. Children assigned to the experimental group received an educational, support treatment. The control group received no treatment. Results from the Child Witness to Violence Questionnaire showed significant differences pre and post-treatment in attitudes and responses to anger and in sense of responsibility for the parents and violence (Wagar & Rodway, 1995). No significant differences were found between the two groups in terms of knowledge of support and safety skills (Wagar & Rodway, 1995).

A qualitative study by Peled and Edleson (1998) of groups at the Minneapolis Domestic Abuse Children's Program also reported positive results. Children enrolled in this 10-week program gained knowledge in the following areas: the different kinds of abuse, how to protect themselves in case the violence recurred, how to problem-solve in positive ways, and that other children have had similar experiences. This evaluation study also found unintended negative results: several children showed signs of discomfort when the discussion focused on sexual abuse; several children did not want to discuss the violence they witnessed between their parents; and several children misinterpreted confidentiality and were reluctant to discuss group activities with their parents. Overall, Peled and Edleson (1998) reported that children and their parents benefited from the group intervention.

Sudermann et al.'s (2000) evaluation study of the London (Ontario) Group Treatment Program also reported some positive results. The researchers found the following: a positive change in the children's attitudes and beliefs about woman abuse, peer abuse, and other forms of violence; the children learned about the different forms of abuse (physical, verbal, sexual); the children learned who was responsible for the violence; the children learned how to act to be safe and that protecting themselves was the first priority; and the group expanded children's knowledge regarding social supports.

A recent evaluation study by Pepler, Cattello, and Moore (2000) of the Children's Peer Group Counselling Program (Women's Habitat, Toronto) also reported encouraging results. Changes were noted in the children's self-reports of depression and anxiety (i.e., improvement following the program), and mothers reported an improvement in their children's emotional and hyperactive behavior problems. The researchers further

reported that there appeared to be no change in the children's problem-solving strategies and attitudes regarding parental violence although these children were found to be well adjusted in these areas at the onset of the program. In addition, this study found that mothers' participation in counselling was not associated with their children's improvement. This finding contradicts Wagar and Rodway's (1995) assertion that group work is more effective when parents are receiving some form of counselling concurrently with their children's program.

Limitations of Evaluation Studies

A number of evaluation studies have been conducted to assess the effectiveness of a group work intervention for children exposed to parental violence. These studies are limited in number and most do not employ a rigorous design. However, the studies that have been conducted provide useful information. Evaluation studies are required in order to give direction on how group work interventions can be developed and refined. These studies are also necessary for funding purposes and to determine if the intervention is effective (Sudermann et al., 2000).

Evaluation studies on group interventions for child witnesses have several limitations. These include large differences in sampling procedures (women in shelters may not be representative of all abused women, representative samples are difficult to obtain), definitions (is the intervention for children who have only witnessed abuse or who have both witnessed parental violence and been a direct victim), and inclusion criteria (who to include for the intervention) (Graham-Bermann, 2001).

Graham-Bermann (2001) argues that "essential confounds" (design elements that can produce misleading results) can weaken the external validity of evaluation studies. Essential confounds can result from the use of inappropriate comparison groups (e.g., participants may have received a portion of the treatment and dropped out), non-independence of participants (participants not independent of the treatment group), and non-independence of people selected to do the evaluations from those selected to provide the clinical interventions. In addition, some studies neglect to use comparison groups making it difficult to determine if an intervention caused the reported changes.

Graham-Bermann (2001) further argues that only a few evaluation studies incorporate existing theory and research in their design and that "there has been a curious disconnection between what is known in the research literature and what is planned in interventions for children" (p. 248). Interventions can benefit from integrating theoretical and empirical knowledge.

Limitations of Group Work

There are several limitations with the group work approach. One limitation is that this intervention will not solve all the difficulties a child may be experiencing. According to Wilson et al. (1989), "Parents and therapists should not view the group as a panacea for all the difficulties a child may have" (p. 184). These researchers emphasize that it is unrealistic to assume that a 10-week intervention program will result in attitudinal change in the child. Family and or individual therapy may be required following participation in a group.

A group approach utilizing an educational model may be ineffective with children exposed to parental violence. Evans and Shaw (1993) assert that educational models ignore the importance of group process and group development. These researchers argue that from their experience, the children's responses to the exercises and interventions seemed superficial. Evans and Shaw (1993) further found that the children appeared to express what they felt would please the group leaders rather than their real feelings.

The group experience may also contribute to increased feelings of isolation for some children (Peled & Davis, 1995; Peled & Edleson, 1998). The child who has been sexually abused for example, may compare herself with others and learn that she is the only group member who has been a "direct victim". Rather than helping her to feel less isolated, the group experience may increase her feelings of isolation.

Peled and Davis (1995) add that a child's participation in group can impact family members:

> The process of defining interactions as abusive also can cause unintended stress for family members. Several mothers reported that their behavior was criticized by their children, who used the new information gained in the group. In light of new knowledge acquired in the group, children may re-evaluate their parents' behavior and parenting style. This appraisal occasionally has put parents in uncomfortable and even stressful positions. (p. 90)

Conclusion

Children exposed to parental violence are at risk of experiencing short term and long term difficulties. Although the literature suggests that the majority of child

witnesses will not suffer negative consequences from their experiences, interventions are essential for children who are presenting with the "warning signs." Based on anecdotal and empirical evidence, the group work approach appears to be an effective form of treatment for children exposed to parental violence. However, a thorough assessment of the child is necessary prior to his or her participation in group. It is with this theoretical and empirical knowledge in mind that a group work approach was chosen to help children who had been exposed to parental violence.

CHAPTER 3

Description of the Practicum

Setting

The practicum was conducted at the Elizabeth Hill Counselling Centre (EHCC), a non-profit organization that provides counselling services to individuals and families who are self-referred or referred by various agencies. EHCC is a training facility for social work and psychology students from the University of Manitoba. Student clinicians provide counselling services to clients and are supervised by faculty members and permanent staff from EHCC.

Supervision and Committee Members

Supervision for this practicum was provided by Dr. Diane Hiebert-Murphy, my faculty advisor and chair of my committee. Two-hour supervision meetings were held once a week at the EHCC to discuss the progress of the children's group and to review videotaped sessions. Linda Perry, MSW, Program Manager of child therapy services at the EHCC led the children's group in the parent-child group program and provided feedback for this practicum. Mitch Bourbonniere, MSW, a social worker at the Child Guidance Clinic also provided feedback and suggestions for this practicum report.

The Intervention

This practicum involved facilitating two psycho-educational groups for children exposed to parental violence. One group was part of an ongoing parent-child group program while the other group was a children's group developed specifically for this

practicum. While the mother's group was an important component of the parent-child program, this practicum report focuses on the children's group that was a component of the overall program. A comparative analysis between the two children's groups is presented. As well, the similarities and differences between the two children's groups are discussed. For the purposes of this practicum report, "Group 1" refers to the children's group in the parent-child group program, and "Group 2" refers to the subsequent children's group that did not include a parent component.

Group 1

A parent-child group program was implemented at EHCC from September 2001 to December 2001. The two groups (the mothers' group and the children's group) ran concurrently for 12 weeks and met once per week. The weekly format involved the two groups meeting separately for 1 hour followed by a multi-family group session in which the mothers' and children's groups were brought together. The purpose of the parent-child group program was to strengthen the mother-child relationship in families with a history of parental violence. The program uses Theraplay (Jernberg & Booth, 1999) techniques in addition to other interventions commonly used in groups for women and children affected by partner violence.

Therapists involved.

The mothers' group was facilitated by two female graduate students. One student was responsible for planning and facilitating the multi-family group program. My role in this program was to co-facilitate the children's group with Linda Perry.

Referral process.

Notices were sent to social services agencies including Winnipeg Child and Family Services , and Child Guidance Clinic. These notices included information regarding eligibility requirements, the type of therapy being offered, weekly themes, and goals of the groups.

Eligibility criteria.

To be eligible for this program, mothers had to have a history of partner abuse and be requesting for services for themselves and their children. Children (male or female) had to be between the ages of 7 to 10 years and have been exposed to parental violence. In addition, the mother and child had to be living in a safe home environment where the violence has stopped.

Screening and assessment.

The screening process for the parent-child group program involved two assessment interviews. The first interview was conducted with the mother to gather information regarding family history and circumstances surrounding the family violence. The second interview, which involved the mother and child, was used to discuss what the child was exposed to in the home and to introduce the child to the EHCC. The presence of the mother during this interview gives the child permission to talk about the violence.

Goals of the group.

The children's group gave the children the opportunity to understand and process the violence that they had witnessed. One of the goals of the group was for children to learn socially appropriate ways of resolving conflict. Additional goals included helping the children to understand that the violence in their families was not their fault, assisting the children to develop problem-solving skills, and to enhance the children's self esteem.

Weekly themes.

The following weekly themes were discussed in Group 1:

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

Non-threatening age-appropriate activities were utilized to facilitate discussion about family violence and to create a fun atmosphere for the children. According to the

family violence literature, discussing family violence issues can be a potentially anxiety-provoking activity for some children. To address this concern, the children were provided with a snack during group sessions. Snack can help to create a nurturing environment for group members and can also satisfy hunger pains (Nisivoccia & Lynn, 1995; Peled & Davis, 1995). The group facilitators took turns serving snack to model appropriate male-female interaction (Loosely, 1997; Peled & Davis; 1995, Rose; 1998). The children expressed an interest in sharing this responsibility and took turns serving snack each week. In addition, a variety of physical activities (e.g., Simon Says, stretching exercises, Duck-Duck-Goose-Goose) were utilized to help reduce anxiety in the children.

Group 2

The second children's group was implemented at the EHCC from February 2002 to April 2002. My role in this group was to recruit potential group members, schedule intake sessions, and to plan the weekly sessions. Crystal Black, a social work student from the University of Manitoba was my co-therapist for this group. Preparation for each session involved meeting with Crystal for 2 hours every week to discuss group objectives.

Referral process.

Clients on the EHCC waiting list were considered for the children's group. In addition, notices were sent to several community agencies around the city including

Winnipeg Child and Family Services, family drop-in centres, and community centres. Notices were also sent to several school divisions.

These notices included the following information (See Appendix A):

- Duration, and location of program
- Start date
- Contact persons
- Criteria for eligibility

Inclusion criteria.

Criteria for this group included children between the ages of 9 to 11 years who had been exposed to parental violence. A second criterion required that the mother and child had to be living in a safe home environment where the violence had stopped. A number of investigators (e.g., Stephens, 1999; Wolfe & Korsch, 1994) stress the importance of ensuring that the violence in the home has stopped in order for children to benefit fully from the group intervention.

Children who were living at home with ongoing violence were excluded from participating in the children's group. According to the family violence literature, the child who is living in constant fear will not feel safe and will not benefit fully from the group experience (Stephens, 1999; Wolfe & Korsch, 1994). The literature also recommends separating siblings. According to Mullender and Morley (1994), siblings may interrupt each other or act as rivals if they are participating in the same group.

The children's group was postponed for two weeks due to a shortage of participants. Several school personnel and parents called the EHCC to inquire about the

group. However, only five mothers expressed an interest in this program. One child who met the eligibly requirements was unable to participate in the group due to issues related to parental consent (parents had joint custody of the child and the father, according to the child's mother, would not sign the necessary consent forms).

There are several possible reasons that may account for the limited number of participants in the children's group. One obstacle appears to be issues related to transportation (i.e., did not own a vehicle or could not afford to pay for bus tickets). A family counsellor informed me that transportation has been an issue with many of her clients. I informed her that EHCC would provide bus tickets for the mothers who would be interested in having their children participate in the children's group. She said that she would pass this information to her clients. After several days, this family counsellor called and said that the mothers were still undecided about the group program.

Another possibility relates to the readiness of the child to participate in the group. The mother of an 11 year-old said that her daughter could benefit from participating in the children's group. However, this mother later informed me that her daughter was reluctant to come to EHCC for an intake session.

A third possibility relates to the "secrecy" associated with domestic violence. Victims may be reluctant to disclose their abuse for various reasons (e.g., embarrassment, fear from further abuse). Consequently, some victims may choose not to seek help for themselves and their children.

Screening and assessment.

Four boys met the eligibility requirements for the children's group. An intake session with the mother and child was scheduled to assess the appropriateness of the group intervention. Three intake sessions were conducted at EHCC. The fourth intake session was conducted at the home of one of the participants due to time constraints.

The intake session was utilized to obtain background information on the family. Each family was asked the following questions:

- (To mother) Can you share with us why you and your child are here?
- Who is in your family and what are their ages?
- Where is his or her father (abuser) currently living?
- (To child) How often do you see him?

Group leaders were also interested in the violence the child was exposed to. These questions were used to assess if the child is able to talk about the violence he or she had witnessed at home:

- (To mother) Can you tell us about the violence that you experienced at home?
- (To child) Can you tell us what you remember seeing or hearing? What did you do when you saw your mom and dad fighting? How did you feel? What do you do when you are angry?

The intake session can benefit the parent and child by alleviating some of the anxiety associated with the group and its emotionally charged content. This session also allows the parent and the child to become familiar with the agency and the program in a gradual and safe manner (Peled & Davis, 1995).

The appropriateness of the child's participation in group was assessed using the following questions: (To child) Have you ever been in any type of group program before? Would you be interested in being part of this group? Peled and Davis (1998) also recommend providing group members with a tour of the agency where the group program will take place.

Goals of the group.

One of the goals of this group was to give the children an opportunity to process and understand the violence that they had witnessed. A second goal was to assist the children to develop social skills. A third goal was to teach the children socially appropriate ways of dealing with anger.

Weekly themes.

Several weekly themes from the Wilson et al. (1989) intervention model were utilized for this group:

Week 1	Orientation and confidentiality
Week 2	Good and bad secrets
Week 3	Different kinds of feelings
Week 4	Different forms of abuse
Week 5	Fighting in families
Week 6	Dealing with angry feelings
Week 7	Sharing personal experiences
Week 8	Responsibility for the violence

Week 9	It's O.K. to have mixed feelings
Week 10	I have the right to be safe
Week 11	What I like about myself
Week 12	What we have learned and saying good-bye

Several ideas came from the Peled and Davis (1995) manual including: an "Abuse is Not O.K" poster that the children constructed, a group rules contract (children signed this contract), relaxation activities, and "getting to know you" activities.

A variety of learning tools were used to facilitate discussion around family violence including: a 30-minute video--"Feelings: Glad, Mad and Sad" (Robbins, 1993) that presented several conflict scenarios and positive ways of resolving these conflicts, role-plays demonstrating the different forms of abuse, story-telling, and a modified version of the game show "Who Wants to Be a Millionaire?" (Who Wants to Be a Good Problem Solver?).

Evaluation Plan (Group 1 & Group 2)

Pre-and post-test measures were administered to detect any changes in the children following their participation in the group. Group 1 and Group 2 were administered the following measures:

- Child Behavior Checklist (Achenbach, 1991)
- Piers Harris Children's Self-Concept Scale (Piers & Harris, 1984)
- Client Satisfaction Questionnaire

The measures were administered during the intake session and within 2 weeks following the final group session. Mothers completed the Child Behavior Checklist

(CBCL; 1991) and the children completed the Piers Harris Children's Self-Concept Scale (PHCSCS; 1984). Group leaders assisted by filling out the children's response on the PHCSCS. The mothers and their children were also requested to complete a Client Satisfaction Questionnaire (See Appendix B) following the final group session.

The CBCL (Achenbach, 1991) was chosen for its strong psychometric properties. This instrument was also selected because the family violence literature reports that children exposed to parental violence are at risk for developing negative outcomes. The CBCL (Achenbach, 1999) is useful for its ability to identify problem areas in these domains. Furthermore, the identification of problem areas can assist group leaders to determine group goals.

The PHCSCS (Piers & Harris, 1984) was selected for its strong psychometric properties. This instrument can also help group leaders to determine group goals. If a group member's score on the PHCSCS indicates a low self-concept at pre-test, group leaders may use activities that can enhance self-esteem. The PHCSCS was also selected because there is evidence that some children exposed to parental violence show problems with self-esteem (Edleson, 1999; Mullender & Morley, 1994).

Overview of Measures

Child behavior checklist (CBCL).

The CBLC is a parent self-report instrument developed by Achenbach (1991). This 113-item questionnaire is designed to assess social competencies and behavior problems of children ages 4 through 16 years. The CBLC takes approximately 20 minutes to complete and requires a 5^{th} -grade reading ability (Achenbach, 1991). This

instrument can be self-administered or administered by an interviewer (Achenbach, 1991).

The social competencies section of the CBLC looks at three areas: the child's participation in various activities (parents are asked to compare their child with other children on the amount of time spent in these activities), the number and frequency of contacts their child has with peers, and the child's academic performance (e.g., parents are asked if their child has ever been in a special class or if their child has ever repeated a certain grade).

The second half of the CBLC asks parents to identify any behavior problems their child may be exhibiting. Parents consider both observable child behaviors (e.g., argues a lot, can't sit still, destroys his or her own toys) and behaviors that require more general inferences (e.g., unhappy, sad, or depressed). After each behavior problem is described, parents choose the answer that best describes their child on a three point rating scale (0 = not true, 1 = somewhat or sometimes true, 2 = very true or often true).

The CBCL is reported to have a high test-retest reliability (.952 for one week test-retest, and .838 for a three-month test-retest) for non-referred samples (Achenbach, 1991). This instrument is easy to administer and has well-established norms (Achenbach, 1991). The CBCL has also been used in several studies that investigated the effects of witnessing parental violence on children (e.g., Graham-Bermann, 2000; Holden & Ritchie, 1991; Levendosky, 2000). The limitation of the CBLC is its heavy emphasis on an individual child's pathology and neglects other important systems (e.g., the family system) in the child's life that quite likely impact on the child's behavior (Achenbach, 1991).

As mentioned previously, children exposed to parental violence are at risk of developing emotional (internalizing behaviors) and behavioral (externalizing behaviors) problems. The CBCL was selected for its ability to identify problem areas in these domains. However, Achenbach (1991) cautions that the child's profile should be used as a "standardized description of behavior, as seen by the person filling out the CBCL" (p. 236). Results from the CBCL should also be integrated with other data (Achenbach, 1991).

Achenbach (1991) reports that it is possible to compare the profile of a child at different points in time. For this practicum, the mothers completed the CBCL during the intake session and within 2 weeks following the final group session.

T-scores higher than 70 are considered to be clinically significant and correspond to greater than the 98th percentile. T-scores that fall between 67 and 70 fall within the borderline clinical range and correspond to between the 95th and 98th percentile respectively.

Piers-harris children's self-concept scale (PHCSCS).

The Piers-Harris Children's Self-Concept Scale (1969) is a self-report rating scale consisting of 80 statements that measure self-concept as it is addressed through children's evaluation of their behavior, intellectual and school status, physical appearance and attributes, anxiety, popularity, and satisfaction (Piers, 1984; Piers & Harris, 1969). This instrument is designed for use with children and adolescents ages 8 to 18 years. The PHCSCS requires a 3rd grade reading level (Piers, 1984).

Piers (1984) reports that the PHCSCS is easy to administer (takes approximately 15 to 20 minutes to complete), score (hand-scored using templates or using a computerized scoring method), and interpret (can take 30 minutes to interpret). Piers (1984) further reports that trained technicians and para-professionals can administer, score, and interpret this instrument when supervised by a qualified professional.

Psychometric properties of the PHCSCS is strong. Internal consistency is high, with alpha coefficients of .90 - .91 with male and female populations (Piers, 1984). Test-retest reliability range from .62 - .96 with re-test intervals of a few weeks to 6 months (Piers, 1984).

The PHCSCS has several limitations. One limitation with the instrument is its accessibility. Piers (1984) reports that a user with a relevant master's level training or better is allowed access to the test. A second limitation with the PHCSCS is the possibility that the child completing the measure may respond to questions in such a way as to make him or her look favorable (social desirability bias) (Piers, 1984). A third limitation is that the instrument is not appropriate for all ages. Piers (1984) cautions that the instrument is not appropriate for children below the age of 8 years and argues that younger children generally do not posses a general sense of self-worth. Piers (1984) asserts that not enough is known about the development and stability of self-concept in younger children. Despite these limitations, the PHCSCS appears to be an appropriate instrument that can assess how children feel about themselves.

The children of both groups were administered the PHCSCS during the intake session and within 2 weeks following the final group session. The pre-and post-test results were compared to assess any changes in the children's self-concept.

The inconsistency and response bias indexes are components built into the PHCSCS to assess the validity of the child's response and to protect against random responses (Piers, 1984). The inconsistency index detects if the child has responded randomly to some of the items (Piers, 1984). A raw score of 6 or more on this item indicates that the child may have responded randomly to some of the items (Piers, 1984).

The response bias index calculates the number of "yes" responses on the PHCSCS (Piers, 1984). A high score on this index indicates that the child is reacting to a social desirability bias (Piers, 1984). Scores that are greater than 52 or less than 24 on this item suggests that the child is responding to this bias.

Average scores on the PHCSCS typically fall within the 31st and 70th percentile and raw scores below the 16th and higher than the 84th percentile are clinically significant (Piers, 1984). A total T score of 40 or below indicates a low self-concept (Piers, 1984).

Client satisfaction questionnaire.

The mothers and their children from both groups were also requested to complete a Client Satisfaction Questionnaire within 2 weeks following the final group session (See Appendix B). This qualitative measure gave the mothers and their children an opportunity to share what they liked and disliked about the group.

Paperwork/Recording

The required consent/permission for observation forms were completed prior to the start of the children's group. Additional paper work required by EHCC were completed. These included intake reports, contact sheets, and termination summary

reports. A personal journal was used to track the progress of the two groups. Personal notes from the videotaped sessions and consultation meetings with my advisor and co-therapist were also included in this journal.

CHAPTER 4

Group Analysis

The names of all the participants (including the mothers and former partners) from both groups have been changed in order to protect their identities.

Participant Profiles

Group 1

Kristin was an 8 year-old Caucasian girl referred to the EHCC by her biological mother Donna. Donna reported that Kristin was exposed to parental violence between her and John, her former partner. Donna stated that John was physically and verbally abusive to Kristin. Donna said that she was concerned with her daughter's defiant behavior at home and school. Donna stated that she and Kristin would benefit from participating in the mother-child group.

Steven, an 11 year-old Caucasian boy, and his biological mother Susan were referred to the EHCC by a social worker from Winnipeg Child and Family Services. Susan reported that her son was exposed to parental violence between her and Tom, her former partner. Susan reported that Steven had been having behavioral difficulties at school. Susan also indicated that her son was becoming physically and verbally abusive towards his three siblings. Susan stated that she was interested in the mother-child group program for herself and Steven.

Dara-Lee was a 9-year-old Aboriginal girl who was referred to EHCC by her biological mother Whitney. Whitney reported that Dara-Lee was exposed to family violence between her and Terry, her former partner. Whitney was concerned that her

daughter was becoming physically aggressive at home and at school. Whitney said that she was interested in the mother-child group program for herself and Dara-Lee.

Group 2

Troy was a 9 year-old Caucasian boy referred to the EHCC by his school counsellor. Troy's biological mother Debra stated that she was concerned with her son's behavior at home and school and reported that her son has been involved in several altercations at school. Debra reported that Troy was becoming physically abusive towards his younger sister. Debra stated that her son was exposed to parental violence between her and Hugh, her former partner. Debra also reported that Hugh is verbally abusive to Troy and often makes negative comments about his weight. Debra was concerned that Hugh's comments were impacting Troy's self-esteem and stated that her son would benefit from the group.

John was an 11 year-old Caucasian boy referred to the EHCC by his school counsellor. John's biological mother Tina reported that her son was exposed to parental violence between her and Robert, her former common-law partner. Tina stated that this exposure is related to John's anger management problems at home and at school. Tina expressed her frustration with the school and felt that that John was being treated unfairly (e.g., privileges taken away, blamed for initiating altercations). Tina stated that her son would benefit from participating in the children's group.

Terry was a 10 year-old Aboriginal boy referred to the EHCC by a social worker from Winnipeg Child and Family Services. His biological mother Vicki contacted the EHCC and stated that Terry was exposed to family violence between her and Sean, her

former common-law partner. Vicki stated that Terry had been involved in several altercations at school and felt that her son would benefit from participating in the children's group.

Steven, a former group member of the parent-child group program, participated in the subsequent children's group. His mother Susan phoned EHCC and stated that Steven expressed an interest in participating in the second children's group. Susan reported that her son continued to have behavior difficulties at home and school and that he could benefit from this group program.

Group Stages of Development

The group work literature suggests that groups tend to move through different stages of development. There is general agreement that groups move through a beginning, middle, and an end. Groups can revert to an earlier stage and development does not occur in a sequential manner.

Group stages have been given names depending on the author. Bales (1950) for example, identifies these stages as Orientation, Evaluation, and Decision-Making. Tuckman (1963) proposes that group stages involve Forming, Storming, Norming, and Performing. Northen (1969) identifies group stages as Planning and Orientation, Exploring and Testing, Problem-Solving, and Termination. The group stage model used for this practicum report was proposed by Garland, Jones, and Kolodny (1976) and involves the following stages:

- Pre-affiliation
- Power and Control

- Intimacy
- Differentiation
- Separation.

The following discussion describes the major characteristics of the 5-stage model proposed by Garland et al. (1976) and how Group 1 and Group 2 progressed through these stages. Prior to this, a brief discussion on group dynamics is presented.

Group Dynamics

Group dynamics refer to the forces that are present when group members interact with each other (Toseland & Rivas, 1998). Group leaders should have a clear understanding of group dynamics so that appropriate interventions can be used. Group dynamics include communication and interaction patterns, cohesion, development of norms, roles, and status (Toseland & Rivas, 1998).

Communication and Interaction Patterns

Communication patterns refer to the way individuals convey meanings and messages to other individuals (Toseland & Rivas, 1998). Communication can be verbal or nonverbal. Communication involves (a) an individual's thoughts, perceptions and feelings and encoding these into language or symbol; (b) the transmission of the language or symbol to another individual; and (c) a receiver decoding the language or symbol (Toseland & Rivas, 1998). Interaction patterns refers to the ways in which members of a group interact with each other. Interaction between members can be (a) "maypole", where the group leader is the central figure and communication occurs from members to

the leader or from the leader to members; (b) round robin, where group members take turns talking; or (c) free floating, where communication can occur between members and the leader (Toseland & Rivas, 1998).

Group Cohesion

Group cohesion refers to the "closeness" of the group. When group cohesion is strong, members generally feel a sense of commonality with one another ("we-ness"). According to Toseland and Rivas (1998), group cohesion is dependent upon on the individual's need for affiliation, the rewards for participating in the group, and the individual's prior experiences with other groups.

Norms

Individuals learn how to behave appropriately in groups through a social control mechanism referred to as norms. Norms are shared expectations and beliefs about how group members are supposed to behave in a group (Toseland & Rivas, 1998). Norms can be learned through discussion (e.g., group discusses rules for appropriate behavior) or are learned through observation (members learn how to behave by observing others).

Roles and Status

Roles refer to the shared expectations about the functions of individuals in the group (Toseland & Rivas, 1998). Roles are a form of social control and prescribe how individuals should behave in certain situations. In small groups, "contextual roles" may emerge such as the quiet one, the clown, the scapegoat, or the rival (Northen, 1988).

"Status" refers to the individual's position or rank in the group in relation to other group members (Toseland & Rivas, 1998). Status in a group may depend on the individual's education, income, competence, ethnicity, age, and or gender (Northen, 1988).

Analysis of Group 1

Group Development and Dynamics

Stage 1 - pre-affiliation.

The pre-affiliation stage can last two to three sessions and is marked by feelings of uncertainty, anxiety, and doubt (Garland et al., 1976). These feelings can surface when group members face the "unknown." The children may wonder: What are the other group members like? Will they like me? Will I have to disclose information that will make me or the others feel uncomfortable? Will I be successful in this group? Group members may also experience anxiety when they find themselves in an unfamiliar environment where they may be required to participate in rituals to which they are unaccustomed (Garland et al., 1976; Toseland & Rivas, 1998). To reduce feelings of anxiety, it was necessary to create a safe environment for the children and to identify their commonalties. A number of group dynamics were evident during this stage including "small talk" communication among members, approach-avoidance behavior, and decision-making.

Two members appeared to show signs of uncertainty. Dara-Lee, for example, asked numerous questions regarding the group including how long each session would last, the number of sessions involved, and the kinds of activities that are planned. Kristin

also presented with some anxiety by exhibiting "clingy" behavior and other nervous reactions (e.g., biting her fingernails, rocking back and forth).

Communication between group members during the pre-affiliation stage is described as "small talk" (Wickham, 1993). Kristin and Dara-Lee talked about their favorite foods, board games, and television shows. Steven talked about his favorite sport and recent movies he had seen. During this early stage, it was important for the children to get to know each other using this form of communication. In addition, it was important to monitor the nature of members' self-disclosure. Disclosing one's experience with family violence at this early stage may cause other members to withdraw from the discussion (Wickham, 1993).

The pre-affiliation stage is also characterized by "approach-avoidance" behavior ---the tendency of members to want to join the others in the group while also maintaining their distance in order to protect themselves (Garland et al., 1976; Toseland & Rivas, 1998). During the first session, Steven decided not to make a personalized name tag and chose to hide underneath a blanket in the corner of the room. As Dara-Lee and Kristin made their name tags, Steven distracted by making animal sounds. Steven's behavior during this activity can be interpreted as approach-avoidance: using distraction (noises) to attract the group's attention while maintaining his distance from the group (hiding). An intervention was to inform Steven about the purpose of making name tags and also recognized that he did not have to participate in this activity if he did not want to. This intervention was necessary to create a safe environment for Steven. This intervention also served as a reminder to allow group members to work at their own pace. Steven joined Dara-Lee and Kristin after several minutes.

As already mentioned, creating a safe environment for the children is an important task during the pre-affiliation stage (Peled & Davis, 1995). Children who have been exposed to parental violence often feel vulnerable and perceive the world as an unsafe place. Child witnesses may also have difficulty trusting others, especially adults. Given these experiences, it was important to create an environment that was safe, warm, and inviting. This involved selecting a room large enough to allow for free play and other physical activities (Peled & Davis, 1995), using brightly-colored floor cushions, designating a "quiet area" for group members who felt the need to be alone, and ensuring that the room would allow for some privacy. Floor cushions were placed in a circular seating arrangement to promote face-to-face interaction (Toseland & Rivas, 1998). It was interesting to note that although the floor cushions were not specifically assigned, the children often occupied the same cushion every session. Perhaps the children felt more secure occupying the same seat every session (Toseland & Rivas, 1998).

Group rules were established to create a safe environment for the children. Group rules serve as a contract between the children and group leaders. They also provide clarity and predictability which are the important components of a safe environment for children (Peled & Davis, 1995). To encourage the children to take ownership of the group, the children were asked to come up with rules they felt would be important for the group to follow. According to Loosely (1997), "A group that makes its own rules is more likely to abide by them" (p. 17). The children came up with the following rules: respecting others' opinions, no fighting, no running, and no swearing. The children agreed that these rules were important to make the group a fun and safe place. Establishing these rules were also necessary to develop the norms of the group.

The norms of the group appeared to have been established by the end of the third session. The children understood the importance of being on time for each session, respecting each other's opinions, and treating each other courteously. They were also aware of the importance of turn-taking during circle-time.

Self-disclosure can an anxiety-provoking activity for group members. The child may wonder, "Will the information I share with the group find its way outside the group?" The group work literature recognizes the importance of discussing confidentiality with the children (Loosely, 1997; Peled & Davis 1995). Confidentiality was addressed during the 1st group session. The children were informed that information shared by group members must stay within the group. The limits of confidentiality were also discussed in this group. The children were informed that at times group leaders may need to share information with other adults (e.g., parents, police, etc.).

Helping members to develop a sense of "we-ness" (Wickham, 1995) is another important task for group leaders. This was accomplished using the following statement, "The children in this group share something in common. Every child in this group has seen fighting between their parents." This statement was used to develop the "We are all in the same boat phenomena" among group members. This statement was also a form of risk-taking (saying the "taboo") (Nisivoccia & Lynn, 1995). In addition, the group leaders used "In Common" (Peled & Davis, 1995) activities to elicit commonalties from group members (e.g., asking members to discuss favorite foods, movies, games, subjects in school etc.).

By the end of the 2nd session, it was apparent that the children shared some commonalties. Dara-Lee and Kristin shared that they both like to tell jokes, play with

friends, and talk on the telephone. Steven said that he enjoyed making people laugh. It was also apparent that the children enjoyed snack time. In sum, Dara-Lee, Kristin, and Steven were beginning to develop a sense of "we-ness" which would later become an important component in group cohesion.

The group members were showing the characteristic behaviors that Garland et al.'s (1976) stage theory predicts. It was not surprising that Steven, Dara-Lee, and Kristin made attempts to get to know one another using small talk.

As previously mentioned, the stage model proposed by Garland et al. (1976) predicts that members will use small talk to get to know one another during the pre-affiliation stage. While this type of communication was evident for the most part, one member in particular seemed to behave in a way that was not characteristic of this early stage. During the 2nd session, Steven disclosed that his father had hit him with a leather belt. A feeling of surprise came over me as I did not expect any of the members to self-disclose during this early stage. I was concerned that group cohesion had not developed and that Steven's comments may cause the other members to withdraw (Wickham, 1993). As an intervention, I acknowledged Steven's revelation concerning his experience of being abused but chose not to probe any further at this time.

It was evident that the cohesion of the group was not strong given that Steven, Kristin, and Dara-Lee were only getting to know each other at this stage. Interaction between these three can be described as "maypole" where communication flows from the members to the group leaders and vice versa (Toseland & Rivas, 1998).

Stage 2 - power and control.

When the major tasks associated with the pre-affiliation stages are completed, the group moves into the power and control stage. Group members begin to test themselves in relation to others to learn about their own status in the group (Garland et al., 1976). During this stage, the group leaders' tasks involve building group cohesion and trust, reinforcing norms, and setting boundaries.

Some members will explore their status by attempting to dominate group discussions (Wickham, 1993). Steven, for example, demonstrated his knowledge about family violence by answering the questions that the group leaders asked.

Dara-Lee explored her status in the group by testing limits with one of the group leaders. This occurred during an activity that required the group to come up with several ways that hands can help or hurt others. Dara-Lee asked if she could write each group member's response on the board with a marker. She was told that one of the group leaders would take on this responsibility. She insisted and grabbed the marker from the group leader's hand. Dara-Lee's response was her way of challenging authority and asserting her independence. Rather than focusing on Dara-Lee's act of defiance, I recognized that this was a normal response from group members during the power and control stage. I intervened by reinforcing group norms and the importance of sharing responsibility.

Formation of alliances can occur during the power and control stage (Garland et al., 1976). This was evident in the relationship that was developing between Dara-Lee and Kristin. The two girls sat next to each other during circle time, exchanged stories, and were playful with each other.

Subgroups can negatively impact the cohesion of the group. Toseland and Rivas, (1998) state that "subgroups can disrupt the group by communicating among themselves while others are speaking. Subgroup members may fail to listen to members who are not part of the group" (p. 72). During one session, Steven disclosed that he was physically abused by his father. Kristin and Dara-Lee were making faces at each other and did not appear to be paying attention to what Steven was saying. Steven retaliated by making distracting sounds when the two girls shared their own experiences. During this incident, the group leaders intervened by reinforcing the rule of listening attentively to the person speaking. Steven was asked to share how he felt when Kristin and Dara-Lee were not listening to him. Steven said that he felt "hurt and sad" that the two girls were not listening to what he had to say. The intervention appeared to be effective. Dara-Lee and Kristin agreed that they would also feel disappointed if others were not listening to what they were saying.

Several group roles became apparent by the 4th session. Steven assumed the role of clown and enjoyed making the other group members laugh. Kristin played the role of the "shy and quiet one." Dara-Lee assumed the role of the "independent child", and seemed to be content with working on her own.

The cohesion of the group was beginning to develop by the 4th session. Steven, Dara-Lee, and Kristin stated during check-out that they enjoyed seeing each other and that the group was "a lot of fun." The three children had a perfect attendance record and appeared interested in the group activities.

The three members took ownership of the group during the 4th session. This was evident when the children began to voice their opinions about activities they liked and disliked, the kinds of snack they preferred, and how each group session should end.

Stage 3- intimacy.

Group members experience a sense of belonging during the intimacy stage. Relations are more intimate and less formal (Garland et al., 1976). The group is viewed as a "special place" (Wickham, 1993). By the end of the 6th session, Dara-Lee, Steven, and Kristin had reached this stage. The three children were comfortable with each other (e.g., sharing jokes, experiences at school, and talking about similar experiences) and were more secure in their environment.

The cohesion of the group during this stage was very strong. Members spoke positively about the group including the group activities. Self disclosures from group members increased. Kristin, for example, disclosed that she was physically abused by her father. Steven talked about his anger towards his father for hitting his mom. Dara-Lee described her ordeal of running to a payphone to call for help. It was apparent that the group had reached a level where members felt safe enough to talk about their experiences. It was also evident that the three members had developed a sense of respect for one another and remained quiet and attentive during circle time.

Ambivalent feelings may also re-surface during this stage (Garland et al., 1976). Unlike the ambivalent feelings associated with the pre-affiliation stage (wanting to be in the group but maintaining distance), members feel ambivalent about how much information should be disclosed. Kristin, for example, stated that her father would

discipline her with a kitchen utensil. When asked how she felt during the incident, Kristin quickly replied, "Bad!" and giggled. She did not elaborate any further. This was the first time that Kristin had disclosed her experience with family violence.

Group leaders play a less dominant role during the stage of intimacy (Wickham, 1993). The group leaders made a conscious effort to "step back" to allow the group members to facilitate the discussion.

Re-enactment of family dynamics typically occurs during the stage of intimacy (Wickham, 1993). This occurs when members feel comfortable in the group and begin to assume the role they play in their own family. Steven, for example, assumed the role of the comedian to introduce levity into the group and to hinder serious discussion. Dara-Lee assumed the role of the "cute child" and would often sit on her mother's lap during the multi-family group. Kristin continued to play the role of the "shy and quiet child."

There were a number of personal challenges for me during this stage. One challenge was that at times, I felt uncomfortable and unaccustomed to playing a less dominant role within the group. I recall having to remind myself that as group cohesion became stronger, it was necessary for group leaders to step back to allow mutual support among members to develop. This feeling of discomfort may be related to my eight years of experience as a child care worker where my responsibilities included initiating and leading group activities. It was helpful to remind myself of the importance of knowing the stage the group was in and allowing Steven, Dara-Lee, and Kristin to assist one another.

I was becoming concerned with the relationship that was developing between Kristin and Dara-Lee and the effect that this would have on the overall cohesion of the

group. Emotional bonds and alliances normally form between members in groups (Toseland & Rivas, 1998). However, I was concerned that Steven would feel alienated. To address this issue, group-centred activities were utilized to encourage members to work together as a whole.

Stage 4 – differentiation.

The following characteristics are common during the stage of differentiation: differences between group members begin to emerge, increase in positive/constructive feedback, and members sensitively challenge each other to make changes (Garland et al., 1976). Toseland and Rivas (1998) point out that most of the group's work occurs during this stage.

Garland et al's. (1976) stage model suggests that challenges among members increase at this stage. However, challenges among members of this group this not occur often. The children of this group rarely challenged each other to make changes. On one occasion, Dara-Lee questioned Steven for his pre-occupation with revenge (e.g., Steven often talked about getting his father back for hitting him). Dara-Lee explained that there were alternative ways to resolving conflicts (e.g., telling mom or another adult).

During this stage, I played a less dominant role as the group became more cohesive. Mutual aid between the members had increased at this stage. Dara-Lee, Kristin, and Steven often helped each other during group activities. Another example of mutual aid occurred when Steven acknowledged that Dara-Lee made the right decision by calling for help when mom and dad were fighting.

Group members will test new behavior during the stage of differentiation (Garland et al., 1976). Steven, for example, distracted the group during an earlier stage by making inappropriate sounds. One intervention was to acknowledge his talent for imitating different sounds and sensitively challenging Steven to imitate sounds that were not considered inappropriate (e.g., birds chirping, cartoon characters). During this stage of group development, Steven began to imitate these new sounds more frequently and imitated unpleasant sounds less frequently.

One of the group activities required the children to imagine riding on a magic carpet and stopping at a place to have some tea. The children were instructed to take turns pouring tea, passing out biscuits, cups, and napkins. The purpose of this exercise was to teach social skills and to encourage the children to use their manners. Steven, Kristin, and Dara-Lee seemed to enjoy this make believe tea time.

Group members begin to see themselves as unique individuals during the stage of differentiation (Garland et al., 1976). When the group was asked, "What would you do if someone did something to you that you did not like?" Each child responded differently to this question. Steven said that he would "get the person back." Kristin replied that she would ignore the person and walk away. Dara-Lee shared that she would tell an adult. The differences in the children's response reflects each child's uniqueness. This exercise helped the children to realize that although they had many things in common (e.g., all have witnessed family violence), they are unique individuals. It was important for the children to realize that their differences made them unique individuals.

The group roles remained consistent during this stage. Steven remained as the clown of the group and continued to make the group members laugh. He also assumed

the role of entertainer at times and enjoyed showing magic tricks. Dara-Lee continued to assume the role of the independent child while Kristin remained as the "shy and quiet one."

Stage 5 – termination.

During the termination stage, attention was on helping members to begin separating from the group, and assisting members to cope with sadness. The group work literature recommends raising termination issues 3 to 4 sessions prior to the final session to prepare group members (Peled & Davis, 1995; Wickham, 1993). Several group dynamics were evident during this stage including anxiety among group members, decision making, and a need to continue.

Denial (the group is not ending because we are not well enough), flight (members dropping out just before termination), and regression (members may revert to an earlier stage of development) are responses that can surface during this stage (Garland et al., 1976). Anger and hostility among group members may also emerge during this final stage. Several group work authors (e.g., Toseland & Rivas, 1998; Wickham, 1993) suggest that these feelings are a normal reaction to a perceived threat or upset.

Although the stage model by Garland et al. (1976) points out that members will show signs of denial, flight, and regression, Group 1 did not appear to exhibit any of these characteristics. The children, however, expressed having mixed feelings about the group ending (e.g., sad that the group will no longer be meeting, and happy for completing the program).

A review of the topics discussed in the group commonly occurs during the termination stage (Garland et al., 1976; Peled & Davis, 1995; Toseland & Rivas, 1998). This can help the members to evaluate what they have learned in the group. Kristin, Steven, and Dara-Lee reported that they had learned appropriate ways of resolving conflicts and that using violence to solve problems is inappropriate. Steven reported that at times it is necessary to use violent tactics (e.g., in cases of self-defense) but that he would try the problem-solving techniques he learned in the group. The children also understood that the violence between their parents was not their fault.

The termination stage can be used as an opportunity to discuss the significance of closures outside the group (Nisivoccia & Lynn, 1995; Wickham, 1993). During the final session, the group discussed the different feelings that can arise when a person experiences a loss (e.g., sadness, grief, loneliness). At times, mixed feelings (e.g., sad and happy) can arise. The group was told that these feelings are normal and are part of life.

The termination stage is also characterized by celebrating the group's accomplishments (Garland et al., 1976; Peled & Davis, 1995). A small party for the children and their mothers was planned for the final group session. The children had cake, and ice cream, and played games. Each child received a white T-shirt they could personalize using permanent markers. Dara-Lee, Steven, and Kristin asked the group leaders and mothers to "autograph" their T-shirts with a marker. Each child also received a special certificate for completing the group (See Appendix C). The final session ended with a group picture.

This group was prepared for termination using a Winnie the Pooh Calendar. This calendar reminded the children of the number of group sessions remaining. Dara-Lee presented with some anxiety during the 10th session when she realized that there were only two sessions remaining. Dara-Lee turned to Kristin and said, "Oh-oh… only two more sessions to go!" Steven suggested that group members exchange telephone numbers to keep in touch after the group ended. This appeared to be his way of preparing himself for termination. Dara-Lee and Kristin agreed that this was a good idea.

It was important to provide each child an opportunity to share his or her feelings about the group ending. Dara-Lee reported during check-out that she was going to miss the "fun stuff" and the other group members. Kristin shared that she was going to miss the group leaders. Steven expressed ambivalent feelings with the group ending saying that he was sad that the group was ending but happy that he would be able to see his other friends more often.

In sum, familiarity with the group stages of development was helpful for several reasons. Familiarly with each stage provided an insight into how the group should proceed and at what pace. Knowing for example that it is common for group members to feel nervous and anxious during the pre-affiliation stage made me aware of the importance of creating a safe environment for the children. Awareness of the power and control issues common in the second stage was also important. Rather than getting into a "power struggle" with group members, I was aware that "testing of authority" was the children's way of exploring their status in the group and maintaining their autonomy (Wickham, 1993). Understanding, patience, and empathy were particularly important qualities to possess during this stage. Reinforcement of group norms was also necessary

during the power and control stage. As the children became more secure in their environment, it was important to help members see themselves as unique individuals. Finally, knowing what to expect during termination stage was also helpful because it made me aware that each member may respond differently to the group ending.

Intervention with the Mothers

Intervention with the mothers was an integral part of the parent-child group program. As mentioned previously, the mothers group ran concurrent with the children's group. The mothers discussed how the violence impacted them personally as well as their relationship with their children. In addition, group leaders from the mother's group met with each mother during a follow-up meeting.

My involvement in the intervention process occurred in a number of ways. One way was to assist the mothers during the multi-family group. At times, this involved "coaching" some of the mothers in the activities. During one session, Donna appeared to be having difficulty with Kristin. I approached Donna and said, "C'mon mom, show her (Kristin) who's boss." This comment was used to encourage Donna to assume a more parental role with her child. It was important to convey this idea in a humorous and non-threatening manner.

Providing the mothers with positive feedback was also an important component in the intervention process. During one of the multi-family group sessions, I said to Susan (who had been having difficulty with Steven's attention-seeking behavior), "Susan, I really like the way you used humor to re-direct Steven's attention to the task at hand." Susan responded, "Thanks, whatever works, I guess.".

Another way I was involved in the intervention process with the mothers was to participate in the weekly supervision meetings with Dr. Hiebert-Murphy and the other group leaders. The progress of the two groups was discussed at this meeting. In addition, we discussed the strengths of the mothers, the coping methods they employed, and how the mothers interacted with their children during the multi-family group.

Evaluation of Group 1

Steven.

Table 1 is a summary of Steven's pre-and post-test scores on the CBCL and the PHCSCS. The CBCL indicated that Steven's total problem score was in the clinically significant range. His total T score at pre-test for internalizing problems was in the clinically significant range. His score on all the internalizing subscales (with the exception of the withdrawn subscale) fell within the clinically significant range.

Steven's total T score at pre-test for externalizing problems was in the clinically significant range. His score on the delinquent behavior subscale was in the borderline range (e.g., no guilt and swears). Steven's score on the aggressive behavior subscale was in the clinically significant range (e.g., argues, jealous, fights, has temper, and is stubborn).

Steven's pre-test score on the CBCL is consistent with the family violence literature that suggests that child witnesses experience internalizing and externalizing behavior problems. However, it is important to emphasize that Steven's profile is based on his mother's assessment and should not be used as a "true description" of his behavior.

Table 1

Steven's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	64	54
Somatic Complaints	75*	70*
Anxious/Depressed	88*	72*
Social Problems	80*	68*
Thought Problems	73*	64
Attention Problems	81*	73*
Delinquent Behavior	70*	70*
Aggressive Behavior	83*	69*
Total Internalizing	80*	71*
Total Externalizing	76*	70*
Total Problem	71*	63
PHCSCS		
Behavior	47	54
Intellectual and School Status	70*	63*
Physical Appearance and Attributes	69*	69*
Anxiety	52	69*
Popularity	41*	55
Happiness and Satisfaction	52	63*
Total Score	55[a]	66*

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

Steven's total problem score decreased significantly from 71 at pre-test to 63 at post-test. His total T score for internalizing and externalizing problems also decreased at post-test. Although Steven's total T score for internalizing problems remained within the clinically significant range, his T score decreased from 80 at pre-test to 71 at post-test. The anxious/depressed and attention problems subscales remained in the clinically significant range. His score on the somatic complaints and social problems subscales fell within the borderline range. Steven's total T score on externalizing problems decreased from 76 at pre-test to 70 at post-test. The delinquent behavior and aggressive subscales remained in the borderline range. The overall improvement in Steven's T score fits well with Susan's observation that her son's behavior at home had improved significantly.

Steven's pre and post-test results on the CBCL fit with my clinical observations. At the start of the group, Steven appeared to be having behavioral difficulties and Susan appeared to struggle to find ways to settle him. At times, Steven attempted to distract the group by making noises. However, as the group progressed and when he was given opportunities to be the center of attention, Steven's ability to remain on task and to focus seemed to increase. His externalizing behaviors decreased. Steven's use of distraction also appeared to decrease.

Steven's raw score on the inconsistency index on the PHCSCS was 6 at pre-test suggesting that he may have responded randomly to some of the items on this instrument. Steven's raw score on the response bias index was a concern as well although he scored 2 points below the required 52. These two indexes suggest the possibility that Steven may have been responding to a social desirability bias as well as responding randomly to some

of the items. This implies that his overall score on the PHCSCS should be interpreted with caution.

As shown in Table 1, the PHCSCS indicated that Steven's total T score increased from 55 at pre-test to 66 at post-test indicating that his self-concept improved following the children's group. In particular, he showed improvement in the behavior, anxiety, popularity, and the happiness/satisfaction subscales. His score on the intellectual/school status subscale decreased from 70 at pre-test to 63 at post-test. Steven's score on the physical appearance and attributes subscales remained the same at post-test.

Steven's pre and post-test results on the PHCSCS fit with my clinical observations. Through out the children's group, Steven often talked about himself in positive terms. He often shared that he felt good about his accomplishments at school (e.g., excelled in sports and ability to make friends) and his experiences as a peer counsellor. Steven shared numerous stories of being able to diffuse potentially volatile situations and maintaining peace among the students. In general, Steven presented as a child who felt good about himself.

The client satisfaction questionnaire that Steven and Susan completed also provided valuable information about the group program. In general, Steven and Susan indicated that the group program was a positive experience. According to Susan, the group was beneficial to Steven. When asked, "Have you noticed any change in your child as a result of participation in the group?" Susan responded, "Yes, he has a better understanding of his and others' feelings. He is also playing better with others." Susan also indicated that she enjoyed the activities in both groups. She reported that she liked the small size of the group, the positive comments she received from the other mothers,

and the commonality that group members shared. During the post-group interview, Susan said that the group helped Steven by reducing his feelings of isolation.

Summary.

Steven's post-group results on the CBCL indicated that his internalizing and externalizing behaviors decreased. The PHCSCS indicated that his self-concept increased at post-test. However, due to limitations associated with the pre-and post-group design, it is difficult to determine if these changes resulted from Steven's participation in the children's group, the influence of other factors, or both. Based on my clinical impressions and the results from the client satisfaction questionnaire, I feel that Steven benefited from the children's group. I agree with Susan that the group helped Steven to become aware that family violence can occur in other families. I also feel that for Steven, the cohesion among members was an important component in the group. When asked the question, "What did you like about the group?" Steven responded, "Being here with the group leaders, Dara-Lee, and Kristin, and the other group (mother's group)."

Kristin.

Table 2 is a summary of Kristin's pre-and post-test scores on the CBCL and the PHCSCS. The CBCL indicated that at pre-test, Kristin's total problem score was in the borderline clinical range. Her total T score at pre-test for internalizing problems was in the clinically significant range. Kristin's scores on the anxious/depressed (e.g., lonely, unloved, fearful, and worries) and the attention problems (e.g., can't sit still and nervous)

Table 2

Kristin's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	64	73*
Somatic Complaints	64	64
Anxious/Depressed	81*	79*
Social Problems	68*	63
Thought Problems	70*	70*
Attention Problems	69*	67*
Delinquent Behavior	63	67*
Aggressive Behavior	85*	75*
Total Internalizing	72*	73*
Total Externalizing	77*	74*
Total Problem	67*	67*
PHCSCS		
Behavior	36*	47
Intellectual and School Status	50	52
Physical Appearance and Attributes	49	60*
Anxiety	47	41*
Popularity	41*	51
Happiness and Satisfaction	47	56*
Total Score	46	54

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

subscales were in the clinically significant range. Her scores on the social problems (e.g., clings and not get along) and thought problems subscales were in the borderline clinical range.

Kristin's total T score for externalizing problems at pre-test was in the clinically significant range. Her score on the delinquent subscale was in the borderline clinical range and her score on the aggressive behavior subscale (e.g., argues, mean, is stubborn, teases, threatens, and loud) was in the clinically significant range. This fit well with Donna's observation that Kristin is "hard to get along with when she doesn't get her own way."

At post-test, the CBCL indicated that Kristin's total problem score remained in the borderline clinical range. Her total T score for internalizing problems also remained in the clinically significant range and increased slightly from 72 at pre-test to 73 at post-test. Kristin's score on the thought problems and attention problems subscales remained within the borderline clinical range and her score on the withdrawn subscale increased from normal to within the borderline range at post-test. The CBCL indicated an improvement in Kristin's T score on the social problems subscale which fell within normal range at post-test. Kristin also showed a slight improvement in externalizing problems at post-test. Although her T score on the delinquent subscale remained in the borderline range, Kristin's T score in the aggressive behavior subscale decreased from 31 at pre-test to 25 at post-test.

Kristin's pre and post-test results on the CBCL fit with my clinical observations. At the onset of the program, Kristin presented with behavioral difficulties during group activities and her mother attempted to find methods to deal with her. However, during

the middle and final stages of the group program, there was an improvement in Kristin's behavior. Her mother confirmed that Kristin's behavior towards her siblings had improved. In terms internalizing problems, it was not a surprise to me that there was a slight increase in her score at post-test. This increase may be related to her mother's involvement in court around the time post-test measures were administered. This also seemed to fit with Donna's observation that while Kristin's behavior improved slightly after the children's group, she also became more withdrawn and "kept things inside". Donna believed that her legal battles with her former partner were contributing to Kristin's internalizing behavior problems.

The PHCSCS indicated that Kristin's total T score increased from 46 at pre-test to 54 at post-test indicating that her self-concept improved. Improvements were identified in the behavior, physical appearance/attributes, popularity, and happiness/satisfaction subscales and a slight increase in the intellectual/school status subscale. However, Kristin's T score on the anxiety subscale decreased from 47 at pre-test to 41 at post-test (increase in anxiety). This increase is also evident in her score on the CBCL. It is possible that Donna's legal battle with her former partner may also be contributing to Kristin's anxiety.

Kristin's pre-and post-test results on the PHCSCS fit with my clinical observations. She did not present with any indications of a low self-concept at the onset of the group and throughout the group. The increase in her anxiety was not surprising given that her mother was confronting legal issues with her former partner. This could have impacted Kristin.

Kristin and Donna completed a client satisfaction questionnaire following the group program. In general, they indicated that the group program was a positive experience. Donna reported that children's group was beneficial to Kristin. When asked, "Have you noticed any change in your child as a result of participation in the group?" Donna responded, "Kristin has a better understanding of her feelings." Donna also indicated that the she enjoyed the multi-family group activities. During the post-group interview, Donna reported that she appreciated the positive feedback she received from the mothers and group leaders. She further indicated that she enjoyed learning about the importance of play. When asked if there were any changes that could be made, Donna suggested extending the program for a longer period of time

Summary.

The post-group results from the CBCL indicated a slight increase in Kristin's internalizing behaviors and a decrease in her externalizing behaviors. The PHCSCS indicated an increase in her self-concept at post-test. Based on my clinical impressions and her responses from the client satisfaction questionnaire, I feel that Kristin benefited from the children's group by reducing her feelings of isolation. Kristin also appeared to enjoy the activities in the group and being with the other group members. When asked the question "What did you like about the group?" Kristin responded, "The games, snack, and being with everyone."

Dara-Lee.

Table 3 is a summary of Dara-Lee's pre-and post-test scores on the CBCL and the PHCSCS. The CBCL indicated that Dara-Lee's pre-test scores on internalizing and externalizing problems were in the normal range. At post-test, her score on the internalizing problems decreased from 58 to 52. Dara-Lee's score on the externalizing problems increased slightly from 57 to 60. Her total problem score remained the same at 51. These scores seem to suggest that Dara-Lee did not present with externalizing and internalizing problems and that the group appeared to have very little impact in these particular areas.

Dara-Lee's pre-and post-test results on the CBCL fit with my clinical observations. In general, Dara-Lee did not present with any behavioral difficulties during the children's group and the multi-family group.

Dara-Lee's raw score on the inconsistency index at post-test on the PHCSCS was 6 suggesting that she may have responded randomly to some of the items. Therefore, the validity of her total score is questionable and must be interpreted with caution.

The PHCSCS indicated that Dara-Lee's total T score decreased from 45 at pre-test to 42 at post-test indicating that her self-concept decreased. As shown in Table 3, her score on the behavior, intellectual/school status, and the physical appearance/attributes subscales decreased at post-test. There was, however, an increase in Dara-Lee's score in the anxiety and popularity subscales.

Dara-Lee's pre and post-test results on the PHCSCS did not fit with my clinical observations. Dara-Lee did not appear to show any indications of a low-self-concept.

Table 3

Dara-Lee's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	54	54
Somatic Complaints	56	56
Anxious/Depressed	62	52
Social Problems	56	60
Thought Problems	64	50
Attention Problems	60	54
Delinquent Behavior	50	59
Aggressive Behavior	56	57
Total Internalizing	58	52
Total Externalizing	57	60
Total Problem	51	51
PHCSCS		
Behavior	41*	36*
Intellectual and School Status	50	41*
Physical Appearance and Attributes	53	40*
Anxiety	31*	44*
Popularity	39*	44*
Happiness and Satisfaction	47	47
Total Score	45	42[a]*

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

Although she presented as shy and reserved during the onset of the program, she appeared to be feeling more comfortable in the children's and the multi-family group and often volunteered answers. Given her presentation, it was surprising that Dara-Lee's score dropped slightly. However, as mentioned previously, Dara-Lee had a raw score of 6 on the inconsistency index at post-test suggesting that she may have responded randomly to some of the items on the PHCSCS. Therefore, her T scores on the subscales at post-test should be interpreted with caution.

Dara-Lee and Whitney completed a client satisfaction questionnaire following the group program. They both indicated that the group program was a positive experience. Whitney indicated that Dara-Lee had benefited from the children's group. When asked, "Have you noticed any change in your child as a result of participation in the group?" Whitney responded, " Yes. Dara-Lee is a little more comfortable speaking for herself." Whitney reported that she also felt that the small size of the group contributed to the "closeness" of the group. When asked what changes could be made to the program, she suggested that the location was not convenient for her.

Summary.

The post-test results from the CBCL indicated a decrease in Dara-Lee's internalizing behaviors and a slight increase in her externalizing behaviors. The PHCSCS indicated a decrease in her self-concept at post-test. As previously mentioned, the validity of her score is in question given her score on the inconsistency index. However, I feel that Dara-Lee benefited from the children's group by reducing her feelings of isolation. I also feel that positive feedback she received from the group

increased her self-confidence. When asked, "What did you like about the group?" Dara-Lee replied, "Everything. Playing the games."

Summary of results.

Several themes emerged from the analysis of the results from the CBCL, PHCSCS, and the client feedback questionnaire. One theme is the difficulty in determining what factor caused the changes in the post-test results. This practicum utilized a pre-test / post-test design to evaluate the effectiveness of the group intervention program. Unfortunately, the design is weak and cannot isolate the specific variables responsible for the changes. With respect to Steven's score for example, it is difficult to determine which part of the parent-child program contributed to decreasing his internalizing and externalizing behavior problems. Was it the children's group or the multi-family group? Was it the effect of participating in both groups that contributed to the changes in his overall behavior? Was it the group activities or the influence of the group leaders? Perhaps these changes were influenced by factors outside the group (e.g., maturation, influence of teachers). Therefore, this type of research design does not permit the analysis of other factors that may be responsible for the changes in behavior. The logical conclusion that can be made is that there appeared to be changes in Steven's, Kristin's, and Dara-Lee's score between pre- and post-test. However, whether or not these changes resulted from the group intervention and or other factors are not known.

Another theme that emerges is the importance of incorporating enjoyable and age-appropriate activities into the weekly sessions. Kristin and Dara-Lee indicated on the

client satisfaction feedback questionnaire that they had fun playing games in the group. This is not surprising given the therapeutic value of play (Axline, 1947).

A third theme that surfaced from the analysis of the client feedback questionnaire is that all the mothers have noticed positive changes in their children. As previously mentioned, Susan indicated that Steven has a greater understanding of his own feelings and is getting along better with others, Donna indicated that Kristin is better at understanding her own feelings, and Whitney had noticed that Dara-Lee is more confident of herself and is better at "speaking her mind".

Conclusion

I gained valuable knowledge as a co-therapist working with Linda, as well as working in the multi-family group. From the literature, I learned that domestic violence can impact children in a number of ways (emotionally, psychologically, and socially). I witnessed in this group the emotional impact that domestic violence can have on children. For Steven, the most notable impact was the anger and fear he felt for his father and his pre-occupation with revenge. For Kristin, it was the short-term effects that her mother reported at intake (e.g., nightmares and behavioral problems).

The children's group had a moderate impact on only one child (Steven) in terms of lowering his externalizing and internalizing behaviors. The group intervention did not have a significant impact on Dara-Lee's and Kristin's scores in these domains. However, it is possible that their situations outside of group may have had something to do with this.

In terms of running the children's group with Linda, I learned the importance of being aware of the group stages of development. These stages not only informed me of what to expect, but also guided our intervention. It informed me about the importance of "scanning the group" and being aware of group dynamics, patterns of communication and interactions, and the development of norms and cohesion. It also taught me when to intervene and when to rely on mutual-aid among members.

I learned that although the psychometric properties of the CBCL and the PHCSCS are strong, they are limited. I agree with Achenbach (1991) that users of the CBCL should not rely solely on this instrument to evaluate the child's overall behavior. Furthermore, the child's score is based on the person completing the instrument and his or her subjective feelings.

Analysis of Group 2

Group Development and Dynamics

Stage 1 - pre-affiliation.

The important tasks during this stage include creating a safe environment for the children and identifying their commonalties. Feelings of uncertainty, anxiety, and doubt that were evident in Group 1 were also evident in this group. Terry, for example, presented with some anxiety by wearing the hood of his jacket during the first three sessions. Troy coped with feelings of uncertainty by asking several questions regarding the activities involved, the length of each session, when the group would end, and if the members would be tested on any of the discussion topics. Steven presented with some anxiety by asking if the activities in this group would be similar to the activities in Group

1. These questions seem to reflect the group members' anxiety about the group and this was their way of coping.

Creating a safe and nurturing environment was also an important task for the group leaders. Children exposed to parental violence often come from environments that are unstable and unpredictable. Therefore, it was important to provide the children with a stable and predictable environment. This was accomplished by utilizing non-threatening activities to facilitate learning around family violence, providing the children with a snack to satisfy hunger pains and to reduce anxiety, allowing the children to work at their own pace, and following a predictable routine (e.g., written agenda). Wickham (1993) cautions that pressuring a member to self-disclose prematurely can cause group members to withdraw.

It was important to ensure that the room setting was hospitable and inviting for the children. A large room was chosen to allow for free play and other physical activities (Peled & Davis, 1995). Brightly colored floor cushions were used and arranged in a circular seating arrangement to promote face-to-face interaction (Toseland & Rivas, 1998). As with the Group 1, the children seemed to occupy the same seat every session. This reflected their need to feel safe in their environment (Toseland & Rivas, 1998). A written agenda was also posted every week to provide the children with predictability.

Discussing family violence issues can increase anxiety for some children. To address this issue, a physical break (e.g., stretching exercises, Simon Says, etc.) was incorporated into the sessions. This break gave the children time to relax and unwind.

The importance of confidentiality was also discussed in this group to make the children feel safe in their environment. Unlike Group 1 however, there appeared to be

some confusion with this group about which information could be shared. Two members thought that general information could no be shared with their parents. This confusion was clarified by discussing the limits of confidentiality (e.g., obligation to report cases of abuse) and that it was permissible to talk about the group activities.

Some of the members in this group engaged in "no close ties dialoging" (i.e., "small talk", or superficial conversation) which is typical during the pre-affiliation stage (Garland et al., 1976). During the 1st session, the children were encouraged to introduce themselves to one another. The children appeared to be open to this as each member shook hands with one another. It was during this activity that group members engaged in "small talk". Steven and John talked about sports, school, and favorite television shows. Troy talked to Terry about his favorite sport and the number of people in his family.

As with Group 1, it was important to develop a sense of "we-ness" among the group members. This was accomplished by encouraging the group to talk about similar interests, likes, and dislikes. By the end of the third session, the boys learned that they shared many things in common. The boys shared that they were all into sports. It was also apparent that all the boys enjoyed eating as they inquired about snack. They spoke about their passion for video games and watching scary movies. All the boys agreed that school was "boring" and that homework was not fun. In sum, the group was developing a general sense of "we-ness" which is crucial to the development of group cohesion.

The desire to take ownership of the group seemed to develop more quickly with this group. During the 1st session, John suggested that a "special handshake" be used when members greet one another. Troy suggested that a "closing song" would be a good way to end the group session. I felt that this would be a good way for the group to decide

as a whole and also for them to realize that this was their group. The reaction of the group was positive and after several minutes, the boys agreed to incorporate these two ideas in the group.

Group rules were also established in this group to create a safe environment for the children. It was important for group members to suggest several rules they felt were important. These rules were written on a large sheet of paper and posted during each group session. The rules poster served as a constant reminder for the children.

By having the members come up with their own rules, it was felt that (a) members would take ownership of the group, and (b) group rules were more likely to be followed if they were established by its members (Loosely, 1997). In addition, each member was requested to "sign" the rules poster. Peled and Davis (1995) state that this helps to empower the children and establish the contractual nature of the rules. The boys came up with the following rules: no fighting, no swearing, respecting everyone's opinions, and listening to the person talking.

In terms of group dynamics, the group was at an early stage and therefore, it was not surprising that the interaction was leader-centered. During the first three sessions, I assumed the role of "expert" and facilitated the discussion around family violence.

Group norms developed by the 4th session. The boys understood that certain behaviors were acceptable (e.g. paying attention to the speaker, no fighting, respecting one another) while other behaviors (e.g., teasing, name-calling, and fighting) were not.

Stage 2 - power and control.

The group progressed to the power and control stage when the major tasks of the pre-affiliation stage were accomplished. As previously stated, this second stage is characterized by members exploring their status within the group and challenging authority figures. Group members may also form alliances with one another. During the power and control stage, group leaders focused on building group cohesion and trust, reinforcing norms, and setting boundaries.

Some of the members began to explore their status in the group during the 3rd session. John, for example, attempted to convey his status by presenting himself as "authority figure" and monopolizing group discussions around family violence. He seemed to take great pride in answering all the questions asked by the group leaders. Given the stage that the group was in, I recognized John's need to explore his status within the group. I was concerned however, that the other group members would withdraw from group discussions if this continued. I intervened by acknowledging John's knowledge about family violence and used the following response: "John, it certainly sounds like you know a lot about what to do when family violence occurs. I wonder if we could also hear from the other group members and see what they can come up with?" John seemed receptive to this suggestion.

Steven appeared to be in competition with John for the status of "authority figure" on family violence. He demonstrated his knowledge by attempting to answer all the questions that the group leaders asked. A similar intervention was used with Steven and he responded by allowing the other group members contribute to the discussion.

Testing of authority is common during the power and control stage (Garland et al., 1976). Troy, for example, tested limits with one of the group leaders when he attempted to distract Steven by making faces at him during circle time. After reinforcing the rule about listening to the speaker, Troy continued to distract Steven with his antics. Although it was important for Troy to realize that his behavior was disruptive to the others, I avoided making a "big deal" of the situation. Rather than focusing on the rule being broken, I acknowledged Steven's ability to make others laugh and suggested that he could use his skills after circle time (perhaps during a separate activity). I also found that praising the group members for their attentive listening was more effective than repeating the rules.

John seemed to be aware of the importance of status in the group. During check-out, Terry was handed the "talking ball" (person in possession of this small rubber ball had permission to speak) and began sharing with the group what he liked about the particular session. Before Terry finished sharing, John interrupted and proceeded to share with the group. When John was reminded that Terry was in possession of the "talking ball", John stated, "Oh, Terry has the 'ball of control'."

The formation of an alliance was evident in this group. It was evident for example that Steven and John who were in competition with each other also began to form an alliance with one another. In Toseland and Rivas' (1998) view, the two were developing into a "dyad subgroup." From experience with Group 1, I learned that subgroups can create tension in the group. Members of a subgroup may exclude others who do not belong to the subgroup (Toseland & Rivas, 1998). I was concerned that Troy and Terry would feel excluded from the group as a result of the alliance that was forming

between Steven and John. Furthermore, I was concerned that this alliance could impact group cohesion. In order for the group to progress to the next stage, group cohesion must develop (Wickham, 1993). To address this issue, activities that encouraged group members to work together as a whole were utilized. Activities that emphasized individual competitiveness were avoided. In addition, mixed pairings (e.g., Troy being paired with Steven and Terry being paired with John) were encouraged among the group members.

Several roles began to emerge by session four. As mentioned previously, John appeared to assume the role of "authority figure" by attempting to monopolize group discussions around family violence. Steven, who assumed the role of the "comedian/entertainer" in Group 1, appeared to play the same role in this group. Troy assumed the role of the "follower" as he often imitated the playful antics of both Steven and John. The "shy and quiet one" of the group was Terry who seemed content listening to the experiences of other boys.

Stage 3 – intimacy.

The group progressed to the stage of intimacy when the major tasks associated with the earlier stages were completed. One indication that the group had reached this stage (8^{th} session) was that group cohesion seemed to be stronger than the previous stages. Member interaction was less formal and more intimate. During this stage, group leaders focused on enhancing members' coping and adaptation, building trust and mutual aid, and enhancing conflict resolution.

As previously mentioned, the cohesion of the group was strong during this stage. The four boys spoke positively about the group and looked forward to coming to each session. A sense of "we-ness" had developed. It was during this stage that Terry disclosed that the group was "getting closer" and reported that he was glad that he no longer had to "hold things in anymore". I was impressed with Terry's ability to sense the cohesion of the group. Furthermore, Terry's admission that he "no longer had to hold things in" conveyed to others that the group was a safe and secure place. Another indication that group cohesion was strong was that the four boys often referred to each other as "friends."

During this stage, the children were more open to taking risks and sharing details about what they had witnessed at home. Steven for example shared with the group that he would "get his dad back" for hitting him. He provided specific details on how he was going to accomplish this (e.g., using a wooden machete, putting dad in a headlock). Terry, who appeared to be the quietest in the group, also began to disclose more details during this stage. He remembered witnessing "dad beating up mom at the top of the stairs" and seeing him "stepping on mom's arm." Terry shared with the group that he thought that his mom's arm had been broken during this incident.

The "closeness of the group" also became evident when Troy became ill during one session and fell asleep on the couch. The boys showed their concern in different ways: Steven offered to bring Troy a glass of water, John commented that Troy would feel better if some of the lights in the room were turned off, and Terry suggested that Troy leave the session early so that he could go home and rest. During check-out, I felt that this would be a good opportunity to provide the boys with positive feedback for

showing their concern for Troy. I informed the three group members that their reaction to Troy's condition reflected their caring attitude for another group member. I hoped that providing them with positive feedback would boost their self-esteem.

In terms of interaction patterns, it appeared that the group engaged in a "group-centered" interaction where members interact freely with each other (Toseland & Rivas, 1998). Unlike the first three sessions when communication was leader-centered, the boys appeared to be comfortable talking to each other and initiating discussions on family violence.

Stage 4 – differentiation.

The stage of differentiation is characterized by an increase in mutual aid (Garland et al., 1976). Mutual aid between members occurred when Steven disclosed that he lost his temper one evening and punched his sister who had been bothering him. John validated Steven's feelings saying that he too had a younger sister who could be annoying. He then suggested to Steven that a more appropriate response would have been to "ignore her rather than getting into more trouble." Troy added that Steven could have also dealt with the situation by telling his mother. During this 5 to 10 minute conversation between the group members, I deliberately made very minimal interventions. I recognized that mutual aid among group members had developed and our role at this stage became less central (Wickham, 1993).

As previously mentioned, members will sensitively challenge each other during the stage of differentiation. Challenges among members occurred when Steven disclosed that he would use a toy machete to defend his mom "the next time dad came around."

John challenged Steven by asking, "Is there anything else you could do if he showed up?" and added, "I would have called the police in that situation." Troy then responded to John's suggestion by saying, "the police are never on time." Once again during this interchange, I recognized that mutual aid had occurred and made limited interventions. Group members felt comfortable challenging one another. It was important for members to help each other to maintain cohesiveness.

The cohesion of the group remained strong during this stage. The boys continued to view the group positively and looked forward to coming to group. The boys continued to refer to each other as "friends" during check-out. The special handshake that was developed during the 1st session continued to be used during this stage.

The roles within the group remained consistent during this stage. Steven continued to assume the role of "comedian/entertainer" of the group, Terry remained as the "shy and quiet one", Troy remained as the "follower," and John remained as the "authority figure" of the group.

Stage 5 – termination.

As with Group 1, termination issues were raised prior to the final session of the group to prepare the members. For this group, group leaders reminded the children about the number of sessions left before the final session.

As mentioned previously, the stage model by proposed by Garland et al. (1976) suggests that denial, flight, and regression are common during the termination stage. The boys from this group did not appear to show any of these characteristics. What appeared to be common among the members was a feeling of ambivalence (i.e., happy and sad).

John shared that he was happy that the group was ending for various reasons (e.g., more time for friends, sports activities) but also sad that he would no longer see his "group friends." Terry expressed similar feelings (i.e., happy that the group was ending which would allow more free time to see his friends and sad that he will not see the other group members). Both Troy and Steven also reported having mixed feelings about the group coming to an end.

Group members may react to termination by expressing the need to continue (Garland et al., 1976). Terry inquired about the possibility of another children's group at the EHCC and commented that the group program was "too short." Troy asked if another children's group was starting in the fall and stated that his sister would be interested in participating.

As with group 1, I felt that a review of the different discussion topics would benefit the group to identify what was learned. The group seemed to appreciate this and everyone agreed that violence is an inappropriate way of solving problems and that there are alternatives (through discussion, being aware of anger cues, self-talk, walking away).

A small celebration with the children was planned for the final session. Each child received a special certificate for completing the group. The children were also given thank you cards for attending the group. The final session was used as an opportunity to discuss the meaning of closures outside the group.

Intervention with the Mothers

The intervention process with the mothers was also an important component in this second group program. My involvement in this process occurred in a number of ways. One way was to participate in the weekly supervision meetings with Dr. Hiebert-

Murphy and my co-therapist. During these meetings, we discussed (in addition to discussing the children's group) the strengths of each mother, the coping methods they employed during stressful times, and their relationship with their children. We also discussed the struggles that some of the mothers faced (e.g., financial difficulties, disagreement with school administration).

Another intervention was to call the mothers on a weekly basis. These calls were at times, informational (e.g., answer any questions that the mothers may have regarding the group, to inquire if their child had any difficulties at home or at school during the week) in nature. I found that it was important to ask the mothers if there were any incidents that happened during the week that could impact their child's participation in group. These calls were also used to provide the mothers with positive feedback (e.g., regarding the strengths of their child, ability to "connect" with other group members, their child's insightfulness, patience, and caring attitude towards other group members). Some of the mothers used these calls to "vent" and to talk about the difficulties they were experiencing with their child. Overall, the mothers seem to appreciate these weekly calls. Susan, at the beginning of the 2nd session said jokingly, "You didn't call me this week to find out how Steven's week went." She stated that these calls were helpful for her in that it gave her the opportunity to talk about the difficulties she was having with Steven and his siblings. Debra reported that she appreciated the "weekly updates" she received about Troy's progress in the group.

Support for the mothers involved advocating for the mothers and their children. One example of this took place when Tina expressed her frustration with John's school and its disciplinary practices. Upon Tina's request, I spoke to the guidance counsellor in

to gain a better understanding of the school's policy on handling behavioral difficulties. I advocated for Tina and John by providing the school with general information regarding the group (e.g., activities) as well as information about the effects of children exposed to parental violence. Another example took place when I advocated for Susan during a "systems meeting". This meeting (attended by Susan, myself, and three other individuals who were currently working with Susan) was held to explore support services available to Susan and Steven. Steven's progress in the children's group was also discussed at this meeting.

Educating the mothers about the effects of parental violence on children was another important component in this group program. This occurred prior to the start of the group (during intake) and continued throughout the program. The mothers were provided with information regarding symptoms typical of children exposed to parental violence and the use of non-violent discipline and parenting techniques. In addition, the mothers were informed about the possible side effects that can arise from their children's participation in group (e.g., children's use of terms such as physical and or emotional abuse, increase in behavioral difficulties which may be triggered by discussing emotionally charged content).

Problem-solving with the mothers was another important component in the intervention process. According to Debra, Troy suffered from low self-esteem which she felt was a result of the negative comments made by his father regarding his weight. Debra and I explored different ways to boost Troy's self-esteem. Together, we thought of several ideas including using positive feedback when Troy demonstrated appropriate behavior, supporting Troy's interests (according to Debra, Troy loves to bowl), and

encouraging Troy to tell his father how he feels when he makes negative comments about his weight. Problem-solving with Susan involved thinking of ways to help her cope with Steven including using non-violent parenting techniques (e.g., "1, 2, 3 Magic, taking privileges away, holding weekly family discussions), going for walks, and or engaging in recreational activities. Tina and I explored different activities that might interest John including taking guitar lessons, going to community dances, and going for walks. Problem-solving with Vicki produced some ideas including contacting her social worker for a respite worker to work one-on-one with Terry, the possibility of Terry participating in another children's group, and recreational activities (e.g., soccer).

In sum, intervention with the mothers was an important component in the children's group. Although a mother's group was absent from this program, it was important to provide support for the mothers in various ways.

Evaluation of Group 2

The CBCL was administered to all the mothers at the intake session and within two weeks following the final group session. The pre and post-test results were compared to assess any changes in internalizing and externalizing behavior problems following the group. As mentioned previously, results from the CBCL are based on the respondent's subjective view of the child (Achenbach, 1991).

Steven.

Table 4 is a summary of Steven's pre-and post-test scores on the CBCL and the PHCSCS. The CBCL indicated that Steven's total problem score was in the normal

Table 4

Steven's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	54	70*
Somatic Complaints	70*	84*
Anxious/Depressed	72*	81*
Social Problems	68*	68*
Thought Problems	64	70*
Attention Problems	73*	73*
Delinquent Behavior	70*	73*
Aggressive Behavior	69*	83*
Total Internalizing	71*	81*
Total Externalizing	70*	77*
Total Problem	63	71*
PHCSCS		
Behavior	54	59*
Intellectual and School Status	63*	70*
Physical Appearance and Attributes	69*	69*
Anxiety	69*	63*
Popularity	55	61*
Happiness and Satisfaction	63*	63*
Total Score	66*	68*

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

range at pre-test. However, his total T score for internalizing problems at pre-test was in the clinically significant range. The anxious/depressed (e.g., is nervous) and attention problems (e.g., difficulty concentrating, difficulty sitting still, impulsive, and nervous) subscales were in the clinically significant range. The somatic complaints and social problems subscales were in the borderline clinical range. Steven's total T score on externalizing problems at pre-test was also in the clinically significant range. The delinquent behavior and aggressive behavior (e.g., demands attention) subscales were within the borderline clinical range.

At post-test, the CBCL indicated that Steven's total problem score increased to within the clinically significant range. His total T score for internalizing behavior problems also increased. In particular, there was an increase in the somatic complaints (e.g., aches, nausea, stomach pains, and vomits) and the anxious/depressed (e.g., lonely, out to get others, nervous, suspicious, and sad) subscales. This fit well with Susan's observation that Steven often complained of feeling ill after the group sessions. In addition, Steven's preoccupation with "revenge" was a theme that surfaced on several occasions during group sessions. He stated during one session that "kids at my school who bully others deserve to get hurt."

Steven's total T score for externalizing behavior problems also increased at post-test. The delinquent behavior (e.g., swears) and aggressive behavior (e.g., argues, is mean, disobedient at home, is jealous, and attacks) subscales were in the clinically significant range. This also seemed to fit well with Susan's observation that her son's behavior at home had become "unmanageable" (e.g., often bullying his brother and two sisters).

Steven's pre-and post-test results on the CBCL fit with my clinical observations. During the group, Steven presented with some externalizing behavior problems that seemed to get worse. Steven also had difficulty concentrating on some of the group activities. The increase in his score on the somatic complaints subscale also fits with my clinical observations. On several occasions, Steven commented about experiencing some form of ailment (e.g., headaches, vomiting, stomach cramps).

A number of possibilities may account for the increase in Steven's behavior problems from pre-test to post-test. One possibility is that group discussions around family violence may have triggered these somatic complaints. Susan reported during a phone conversation that although her son looked forward to the group sessions, "something" in the group was contributing to these complaints. Susan further reported that her former partner had returned to the city and that all her children were behaving in a peculiar manner. Perhaps Steven was reacting to this situation. Another possibility for the increase in post-test scores is that Susan (who reported being "stressed") may have been having difficulty parenting Steven which was resulting in increased problematic behavior.

The PHCSCS indicated that Steven's total score increased from 66 at pre–test to 68 at post-test. This suggests that the group had a minimal impact on his self-concept (this slight increase may also be due to measurement error). There were improvements in the behavior, intellectual/school status, and the popularity subscales. There was also a slight decrease in the anxiety subscale score at post-test.

Steven's pre and post-test results on the PHCSCS fit with my clinical observations. Through out the children's group, Steven often talked about himself in

positive terms. He often shared that he felt good about his accomplishments at school (e.g., excelled in sports and ability to make friends) and his sucess as a peer counsellor. Steven shared numerous stories of being able to diffuse potentially volatile situations and maintaining peace among the students. In general, Steven presented as a child who felt good about himself.

Steven and Susan completed a client satisfaction questionnaire following the children's group. In general, Steven and Susan indicated that the group was a positive experience. According to Susan, this second group also benefited Steven. When asked, "Do you feel that the group had a positive or negative impact on your child?" Susan responded, "Overall, I think that it (group) had a positive impact on Steven. Steven was sick every Monday night through the first 4 or 5 sessions. He has matured in his handling of certain situations." During the post-group interview, Susan indicated that Steven enjoyed the children's group and making new friends. She said that Steven would miss coming to group to see the other boys. Susan also shared that she appreciated the weekly calls she received to discuss Steven's progress in the group. Overall, Susan reported that although Steven did not learn anything new in the second group, his experience was a positive one. When asked what changes could be made, Susan suggested extending the program for a longer period of time.

Summary.

Steven's post-test results on the CBCL indicated that his internalizing and externalizing behaviors increased. As previously mentioned, the increase may be due to a number of factors (e.g., group discussions around family violence could be related to

the increase). The PHCSCS indicated that Steven's self-concept increased slightly at post-test. Based on my clinical impressions and the results from the client satisfaction questionnaire, I feel that this group did not have a significant impact on Steven's internalizing and externalizing behaviors. When asked the question, "What did you learn about family violence?" Steven responded, "Didn't learn anything new. Just built on the knowledge from the first group." However, I feel that this second group also benefited Steven in other ways. One way is that unlike the first group where Steven was the only male, this group was comprised of all males. I believe that this commonality made him feel more comfortable in this group. Furthermore, I feel that knowledge he acquired in the first group helped him feel more confident in this group. Steven often shared with the boys what he learned from the parent-child group program.

John.

Table 5 is a summary of John's pre-and post-test scores on the CBCL and the PHCSCS. The CBCL indicated that John's total problem score was in the normal range at pre-test. His total T score for internalizing and externalizing behavior problems were within the normal range as well. At post-test, John's total T-score for internalizing and externalizing problems remained within the normal range although his internalizing score increased slightly from 40 at pre-test to 46 at post-test.

John's pre and post-test results on the CBCL did not fit with my clinical observations. Throughout the children's group, John presented with some externalizing behaviors (e.g., bragging, distracting others, talks much). It was also my clinical impression that John presented with internalizing behavior problems (e.g.,

Table 5

John's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	50	50
Somatic Complaints	50	56
Anxious/Depressed	50	50
Social Problems	56	56
Thought Problems	57	57
Attention Problems	54	60
Delinquent Behavior	63	59
Aggressive Behavior	53	57
Total Internalizing	40	46
Total Externalizing	55	55
Total Problem	45	46
PHCSCS		
Behavior	45	66*
Intellectual and School Status	52	70*
Physical Appearance and Attributes	69*	60*
Anxiety	59*	69*
Popularity	55	55
Happiness and Satisfaction	63*	63*
Total Score	60*	70*

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

difficulty concentrating, sitting still). However, as the group progressed, his internalizing and externalizing behaviors seemed to decrease.

The PHCSCS indicated that John's total score increased from 60 at pre-test to 70 at post-test suggesting an increase in his self-concept. John showed improvements in the behavior, intellectual/school status, and the anxiety subscales. There was a decrease in the physical appearance/attributes subscale.

John's pre-and post-test results on the PHCSCS fit with my clinical observations. During the intake session, John presented as talkative, and an outgoing young boy. He presented as someone who generally felt good about himself. He often shared his knowledge during group sessions and appeared confident in his abilities. The decrease in his score on the physical appearance/attributes subscale however, was surprising given that he often boasted about his good looks and about being a "ladies man."

John and Tina completed a client satisfaction questionnaire following the children's group. In general, they indicated that the group was a positive experience. According to Tina, John benefited from participating in the children's group. When asked, "Do you feel that the group had a positive or negative impact on your child?" Tina responded, "Had a positive impact. I feel that the group made him feel more secure knowing that he is not the only person who has been exposed to family violence." During the post-group interview, Tina indicated that John enjoyed the children's group and learning about the impact of family violence in their lives. Tina further indicated that the most notable difference in John was an increase in his patience. According to Tina, John "calms down when he is mad rather than blowing up."

Summary.

John's post-test results on the CBCL indicated that his internalizing and externalizing behaviors remained within the normal range. The PHCSCS indicated that John's self-concept increased at post-test. Based on my clinical observations and the results from the client satisfaction questionnaire, I feel that John benefited from the group. I feel that the group made him feel less isolated, boosted his self-esteem, and made him aware that the violence was not his fault. Furthermore, John learned that family violence is an inappropriate way to solve problems and that talking to an adult can help. When asked the question, "What did you learn about family violence?" John responded, "It's not okay and I should tell somebody."

Terry.

Table 6 is a summary of Terry's pre-and post-test scores on the CBCL and the PHCSCS. The CBCL indicated that Terry's total problem score at pre-test was in the normal range. His total T score for internalizing problems was in the borderline clinical range. The withdrawn (e.g., secretive, shy) subscale was in the clinical range. The other internalizing subscales were in the normal range. Terry's total T score for externalizing problems was in the borderline clinical range.

At post-test, Terry's total problem score decreased. His total T score for internalizing and externalizing behavior problems decreased as well. This fit well with Vicki's observation that there was an improvement in her son's behavior at home and school.

Table 6

Terry's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	75*	75*
Somatic Complaints	61	50
Anxious/Depressed	62	61
Social Problems	56	56
Thought Problems	64	57
Attention Problems	57	60
Delinquent Behavior	59	70*
Aggressive Behavior	68*	58
Total Internalizing	70*	66
Total Externalizing	67*	63
Total Problem	60	56
PHCSCS		
Behavior	54	66
Intellectual and School Status	59*	63*
Physical Appearance and Attributes	49	60*
Anxiety	69*	69*
Popularity	55	55
Happiness and Satisfaction	52	63*
Total Score	58*	68*

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

Terry's pre-and post-test results on the CBCL fit with my clinical observations. During the intake interview, Terry presented as a shy young boy. He was also the quiet member of the group and did not present with any noticeable externalizing behavior problems during the group sessions.

The PHCSCS indicated that Terry's total score increased from 58 at pre-test to 68 at post-test suggesting an increase in his self-concept. He showed improvements in the behavior, intellectual/school status, physical appearance/attributes, and happiness/satisfaction subscales.

Terry's pre-and post-test results on the PHCSCS fit with my clinical observations. He presented as someone who was generally satisfied with himself. During the final group session, Terry stated that he felt happy with himself for sharing his experiences about family violence. He also stated that he was glad that he did not have to "hold things in anymore."

Terry and Vicki completed a client satisfaction questionnaire following the children's group. In general, they indicated that the group was a positive experience. According to Vicki, Terry benefited from participating in the children's group. When asked, "Do you feel that the group had a positive or negative impact on your child?" Vicki responded, "Somewhat of a positive impact, and also some negative. I feel that my child has learned alot about it." During the post-group interview, Vicki indicated that Terry enjoyed participating in the children's group. She reported that Terry benefited from the group by reducing his feelings of isolation and teaching him alternative ways of resolving conflicts. Vicki further indicated that Terry will miss seeing his friends and

participating in the group activities. In terms of changes to the program, Vicki suggested extending the group for a longer period of time.

Summary.

Terry's post-test results on the CBCL indicated that his internalizing and externalizing behaviors decreased. The PHCSCS indicated that Terry's self-concept increased at post-test. Based on my clinical observations and the results from the client satisfaction questionnaire, I feel that Terry benefited from the group. I feel that the group made him feel less isolated and increased his self-esteem. Furthermore, the group also made him aware of who is responsible for the violence. When asked the question, "What did you learn about family violence?" Terry responded, "I didn't cause the fight to happen."

Troy.

Table 7 is a summary of Troy's pre-and post-test scores on the CBCL and the PHCSCS. Troy's total problem score was in the normal range at pre-test. His total T score at pre-test for internalizing problems was in the normal range. Troy's total T score for externalizing problems was in the borderline clinical range. The subscale item identified as problematic was "no guilt." The aggressive behavior (e.g., stubborn, mood change, and has temper) subscale was also in the borderline clinical range.

At post-test, the CBCL indicated that Troy's total problem score decreased. His total T score for internalizing and externalizing problems were in the normal range. All

Table 7

Troy's T Scores on the CBCL and the PHCSCS.

Measure and Subscales	Pre-Score	Post-Score
CBCL		
Withdrawn	64	50
Somatic Complaints	56	50
Anxious/Depressed	58	50
Social Problems	56	52
Thought Problems	57	50
Attention Problems	60	50
Delinquent Behavior	67*	54
Aggressive Behavior	67*	58
Total Internalizing	60	40
Total Externalizing	68*	58
Total Problem	56	46
PHCSCS		
Behavior	36*	43*
Intellectual and School Status	43*	34*
Physical Appearance and Attributes	40*	23*
Anxiety	48	44*
Popularity	47	39*
Happiness and Satisfaction	36*	30*
Total Score	39*[a]	37*

Note. * indicates a borderline or clinically significant score on the CBCL and PHCSCS.

[a] indicates validity concerns on the PHCSCS.

subscales scores were in the normal range at post-test. Debra reported that Troy's behavior at home improved following his participation in the children's group.

Troy's pre and post-test results on the CBCL partially fit with my clinical observations. During the group sessions, Troy appeared to be presenting with some internalizing behavior difficulties (e.g., difficulty concentrating, can't sit still). Troy showed externalizing problems (e.g., argues, teases, mood change) as well.

The PHCSCS indicated that Troy's total score decreased slightly from 39 at pre-test to 37 at post-test indicating that he has an extremely low-self-concept. At post-test, the intellectual/school status, physical appearance/attributes, popularity, and happiness/satisfaction subscales were all in the clinically significant range.

Troy's pre-and post-test results on the PHCSCS fit with my clinical observations. During the intake session, Debra indicated that her former partner was verbally abusive to Troy. Debra indicated that Troy's father often made negative comments about his weight and physical appearance. It is not surprising that Troy scored extremely low on this measure. However, Troy had a raw score of 6 on the inconsistency index suggesting that he may have responded randomly to some of the questions. Based on his score, the results from this measure must be interpreted with caution.

Troy and Debra completed a client satisfaction questionnaire following the children's group. In general, they indicated that the group was a positive experience. According to Debra, Troy benefited from participating in the children's group. When asked, "Do you feel that the group had a positive or negative impact on your child?" Debra responded, "Yes. Troy has had much better control of his anger. Still some slips. He looked forward to the group every week and he really enjoyed it and will miss it."

During the post-group interview, Debra reported that Troy enjoyed coming to group to see his friends. She indicated that the group benefited Troy by reducing his feelings of isolation in knowing that family violence can also occur in other families. Debra also inquired about the possibility of another children's group and said that Troy's sister would be interested in a similar group. When asked what changes could be made, Debra suggested extending the group for a longer period of time.

Summary.

Troy's post-test results on the CBCL indicated that his internalizing and externalizing behaviors decreased. The PHCSCS indicated that Terry's self-concept decreased at post-test. Based on my clinical observations and the results from the client satisfaction questionnaire, I feel that Troy benefited from the group. I agree with Debra that the group made him feel less isolated. I feel that the positive feedback from the other group members and group leaders helped him to feel good about himself although the PHCSCS indicates the opposite to be true. Furthermore, the group also made him aware of who is responsible for the violence. When asked the question, "What did you learn about family violence?" Troy responded, "Violence is not the kid's fault. It's their conflict to solve and don't get involved with it."

Summary of results.

Several themes emerged from this group following analysis of the results from the CBCL, PHCSCS, and the client feedback questionnaire. As with Group 1, one theme is the difficulty in determining which factor caused the changes in the children's post-test

results. As previously mentioned, this practicum utilized a pre-test / post-test design to evaluate the effectiveness of the group intervention program. Unfortunately, the design is limited and cannot isolate the specific variables responsible for the changes. The only conclusion that can be drawn is that changes in Steven's, John's, Terry's, and Troy's score on the CBCL and the PHCSCS occurred between pre- and post-test. Whether or not these changes resulted from the group intervention and or other factors are not known.

Another theme that emerged from this group is the understanding the children had about who is responsible for the violence. The children indicated that the violence between their parents was not their fault. Furthermore, the group agreed that going to a safe place was necessary during parental violence.

A third theme that emerged is that the mothers of this group noticed positive changes in their children. As previously mentioned, Susan indicated that Steven has "matured in his handling of certain situations, Tina indicated that John is more aware that family violence can occur in other families, Vicki said that Terry has gained a better understanding of family violence, and Debra indicated that Troy is better at anger management.

A fourth theme that emerged from this group is the "closeness" that the group members felt for each other. Steven, John, Terry, and Troy referred to each other as "friends". During circle time on the final group session, the boys reported that they were all going to miss each other, the group leaders, and the fun activities.

Conclusion

I gained valuable knowledge as a lead-therapist working with Crystal. As mentioned previously, I learned from the literature that domestic violence can impact children in a number of ways (emotionally, psychologically, and socially). The emotional difficulties that Steven presented in Group 1 were also evident in this group. That is, Steven's anger for his father appeared to fuel his pre-occupation with revenge (revenge for what his father did to his mother). For Terry and Troy, I heard their struggles to deal with the mixed feelings they had for their fathers—loving and hating their fathers. These ambivalent feelings are common according to the domestic violence literature.

In terms of the group intervention, I learned that our program had a positive effect in all but one child—Steven—in terms of lowering his externalizing and internalizing behaviors. This suggests not all children will benefit from a group intervention. Perhaps other forms of interventions (e.g., individual therapy or family therapy) may be more effective for these children. It is also possible that Steven's situation outside the group may have had something to do with this.

As with Group 1, I learned the importance of being aware of the group stages of development. These stages not only informed me of what to expect, but also guided our intervention. It informed me about the importance of concepts such as group dynamics, cohesion, patterns of communication and interactions, and the development of norms. It also thought me when to intervene and when to rely on mutual-aid among members.

Similarities and Differences Between the Groups

The two groups were similar in many ways including group goals (enhance children's problem-solving skills, reduce feelings of isolation, establish who is responsible for the violence, and assist children to develop safety plans), duration (both groups ran for 12 weeks), and target population (for children who were exposed to parental violence). The two children's groups were facilitated by a male-female co-therapy team. The two groups utilized similar rituals (check-in to see how the children were feeling and check-out to give each child the opportunity to say what they liked about the session, use of an object allowing the person to speak, use of a written agenda). Both groups utilized a circular seating arrangement to promote face to face interaction. Additional similarities between the two groups included: the use of play as a way of releasing stress and anxiety, provision of snack to satisfy hunger and create nurturance, and establishment of group rules to regulate behavior and to ensure a safe environment for group members. Both groups were also time-limited, closed, and structured.

There were however, some notable differences between the two groups. Group 1 and Group 2 differed in terms of parental involvement in the therapeutic process, the number of facilitators involved, the structure, the group process, and the gender composition.

As previously mentioned, Group 1 was part of a parent-child group program in which two groups ran concurrently for 1 hour and joined to form a multi-family group following a scheduled break. During the multi-family group, group leaders used Theraplay (Jernberg & Booth, 1999) to strengthen the mother-child relationship. The purpose of the mother's group was to give them opportunities to discuss the impact of

violence in their lives. In contrast, Group 2 was for children only and did not include a parent component. Although it was hoped that the group would lead to positive changes in the children's relationships with their mothers, the primary objective was to help the children understand and process the violence that they had witnessed.

The parent-child program had a stronger impact on the mother-child relationship than the children's group that lacked the parent component. During the multi-family group, group leaders assisted the mothers to play with their children. During the 6th session, it was noticeable that group cohesion was developing. This was evident by the positive comments that the mothers were giving each other. The parent-child group program also served as a support group for the mothers. The mothers of Group 2 had very little contact with one another. The only occasion that the mothers spoke to each other was when they waited for their children in the waiting room.

The two groups differed in the number of group leaders involved. During the multi-family group, four group leaders were involved. In contrast, Group 2 was facilitated by two group leaders during the 12 weeks. There were several advantages to having four therapists during the multi-family group (e.g., more "eyes" to scan for group dynamics, other therapists were sources of support, and responsibilities were divided among the therapists). However, I often wondered if four therapists intimidated (or distracted) any of the mothers or their children. It would have been interesting to know (either through the client feedback questionnaire or follow-up interview) how the mothers and their children felt about having four therapists present during the multi-family group. Wickham (1993) notes that the more group leaders involved, the more time consuming for program planning, and the potential that group leaders may be in competition with

one another. This can impact the cohesion of the group. Fortunately, competition (or disagreements) among group facilitators did not appear to be an issue with this group.

The two groups differed in the time it took to develop cohesion. Both groups developed cohesion and were able accomplish the major tasks involved at every stage. However, Group 2 seemed to develop cohesion more quickly. During the early stages of group development, Steven seemed struggle making a "connection" with Dara-Lee and Kristin who were both younger than him. It was not surprising that two girls were able to relate to each other more quickly than with Steven. The gender difference and age gap between the members of Group 1, appears to have had an impact on how quickly this group developed cohesion. Toseland and Rivas (1998) notes that "a mixed-gender group may interfere with interaction because of the tendency of children at certain ages to either impress or ignore members of the opposite sex" (p. 159). On one occasion (7^{th} session), Steven was upset with Dara-Lee and Kristin and said that the two girls were not paying attention to him during check-out.

The children in Group 2 often referred to each other as "friends." There are a number of possible reasons why group cohesion developed more quickly with this group including: more homogeneous (members were all boys); Group 2 appeared to have more in common (closer in age, similar hobbies); and fewer number of therapists were involved with Group 2.

Communication patterns were different between the two groups. In general, communication between the members in Group 1 was "leader-centered" in which the leader is the central figure and communication occurs between the leader and member or vice versa (Toseland & Rivas, 1998). In contrast, Group 2 began initially with this type

of communication pattern and as cohesion developed, moved to a "group-centered" pattern where communication is initiated and maintained by members rather than leaders (Toseland & Rivas, 1998).

The interaction patterns between the two groups appeared to be different. In Group 1, Dara-Lee and Kristin interacted and communicated with each other most often. The two girls sat next to each other during every session, took "water breaks" together, and engaged in playful behavior with each other. In contrast, the 4 boys in Group 2 interacted with each other.

CHAPTER 5

Practice and Learning Themes

One of the themes that emerged from this practicum is the level of isolation experienced by the families. Several mothers during the intake session expressed feeling "alone" in their community with few sources of support. One mother reported that her close friends and family were "completely oblivious" to the violence that was occurring in her own family. Some of the mothers talked about struggling with the decision to report the abuse. This is consistent with the family violence literature that victims of partner abuse may be reluctant to report the incident for various reasons. Several mothers shared that notifying the police may have led to further abuse from their partners. Others also talked about being financially dependent on their partners and the stress of having to "pay the bills" on their own. The literature suggests that family violence remains to be viewed as "taboo" in society (Geffner et al., 2000; Peled 1998; Wagor & Rodway, 1995). This view further isolates victims of family violence from their community. I found that the group helped the mothers to feel less isolated hearing others talk about their own experiences. One mother stated, "I thought that I was the only one in my community who experienced this sort of thing."

As previously mentioned, children exposed to parental violence employ various coping strategies to protect themselves emotionally and / or physically. Steven, for example, coped with the violence by presenting himself as "fearless." He often described how he would physically hurt his father if he ever returned home. He also seemed to cope by "getting people back" and using acts of revenge to motivate himself (e.g., hurting other students who have hurt him in the past, claiming to have several

teachers fired from his school who were "mean" to him). Troy's defense mechanism was to employ "emotion-focused strategies" (Lazarus & Folkman, 1984). Terry coped with the violence at home by utilizing "problem-focused strategies" (Lazarus & Folkman, 1984). It was apparent that each child was unique and used coping strategies that were effective for them.

Some of the children had negative feelings for their fathers. This finding is consistent with the family violence literature that children exposed to parental violence will often have ambivalent feelings for their fathers (i.e., loving and hating their father at the same time) (Carlson, 2000; Peled & Davis,1998). Terry, for example, stated that while he still enjoys the supervised visits with his father, he remains angry at him for "almost breaking mom's arm." Troy stated that he enjoys visiting his father on weekends but is worried that he will make negative comments about him or his mother.

There are a number of advantages and disadvantages associated with the parent-child group program and the children's group. The following section discusses these advantages and disadvantages.

Parent-Child Group

One advantage of utilizing the parent-child model is that group leaders can work collaboratively with the parents (e.g., provide suggestions, provide positive feedback). When the two groups combined to form a multi-family group, group leaders were able to observe the interaction patterns between the mothers and their children. Kristin, for example, showed "clingy" behavior when her mother was present. It was also observed that her acting out behavior escalated when Donna arrived. She seemed to be reacting to

Donna's lack of structure and hesitancy in the play activities. Another observation was that Kristin also appeared to reject her mother's attempts to nurture her. It seemed that Kristin was challenging Donna to be more in charge.

Another advantage of the parent-child group model is that having the mothers and their children in the same room creates a context of safety and validation for them (Loosely, 1997). This model can help to restructure the family, allows both the parent and child to talk about the abuse in safe ways, and mothers can share their experiences with each other. Geffner, Jaffe, and Sudermann (2000) add that the parent-child model can help members to break the isolation, minimization, and denial that is commonly experienced by victims of family violence. The presence of the mother in the group also gives the child permission to talk about the abuse (Loosely, 1997).

Family violence can create an enormous amount of stress for family members. The mother who has been abused may be too preoccupied with her own safety causing her to become "emotionally drained" (Carlson, 2000). Geffner et al. (2000) found that some mothers and their children have little time for play. One of the goals of the parent-child group was to strengthen the mothers' relationship with their children. Having the mothers and their children in the same group allowed them to enjoy one another.

Another benefit to utilizing the parent-child model is that children can focus on their own issues without having to worry about their mothers. Evans and Shaw (1993) observed:

> Many children from violent homes are extremely protective of and worried about their vulnerable, hurting mothers. They have frequently sacrificed their own needs in their efforts to "prop up mom." Furthermore, the way in which they

> have helped their mothers have frequently been part of dysfunctional family interactions which may reverse family hierarchy or impede the children's moving out into the world of their peers. For the children whose mothers participated in the mother's group, knowing that their mothers were being taken care of elsewhere seemed to free them to deal with their own issues and to help themselves. (p. 113)

There are, however, a number of disadvantages to utilizing the parent-child group model. The parent-child model is time consuming. Group leaders had to plan for two groups including the content goals of each group, separate and combined group activities to be used, and the discussion topics. In addition, the parent-child model required more group leaders and the use of a second meeting room (when the groups met separately).

The parent-child model can also cause some discomfort for some children who may be reluctant to share information with their parents. Kristin, for example, seemed comfortable sharing with the other children a picture she drew but was reluctant to share this same picture with the multi-family group.

The Children's Group

The main benefit to using the children's model is that the main clients were the children. The goals of this group were to help the children talk about their family violence experiences, provide them with alternative ways of resolving conflict, enhance their problem-solving skills, and assist the children to develop safety plans. While strengthening the parent-child relationship was an important component in the parent-child group, this component was not included in the children's group. In addition, this

model required only two group leaders and one meeting room large enough for free play and other physical activities.

There are, however, some disadvantages to using the children's group model. As previously mentioned, the parent-child model provided the group leaders an opportunity to observe the interaction between the mothers and their children. This was not possible in Group 2 given that the mothers were not part of the group.

Unlike the parent-child group, the children's group did not encourage parent interaction. The mothers in the parent-child group interacted more with each other and served as a support group. The mothers of the children in Group 2 seemed to interact only when waiting for their children in the waiting room. Two of the mothers used the waiting room while their children were in session. The other two mothers left the centre and returned when the session ended. More interaction occurred in the parent-child group given that all the mothers were in the same room and consented to participate in a group for themselves.

Group Work

The group work approach was an excellent way for the children to learn that they were not alone with their experiences. This finding is consistent with the literature that the group experience can help child witnesses feel less isolated when they share their experiences with other members (Loosely, 1998; Peled & Davis, 1995). John shared that he was surprised to learn that family violence can also occur in other families and stated, "I thought my family was the only one that has gone through this." Terry shared that listening to the experiences of other members made him realize that other children have

also witnessed fighting between their parents. He shared that he was relieved in knowing this and stated, "I'm glad that I don't have to hold things in anymore."

The children in both groups seem to understand that the violence between their parents was not their fault. This finding is consistent with the group work literature that the group can help to change children's attitudes about who is responsible for the violence (Grusznski & Brink, 1988; Sudermann et al., 2000). In Group 1, group leaders used puppets to demonstrate fighting in families and who is responsible for the violence when parents fight. In Group 2, the book "Hear My Roar" (Hochban & Krykorka, 1994) conveyed the message that children are not responsible for the fighting between their parents. The group was encouraged to draw a violent incident they had witnessed at home and to circle the person responsible. The boys indicated that their fathers were responsible for the fighting.

The development of group cohesion was crucial. During the pre-affiliation stage of group development, the children engaged in activities (getting to know each other activities) designed to illicit commonalties. These "ice breakers" were effective in helping the children to find common interests. The boys, for example, agreed that group leaders should avoid assigning homework. Steven and John found that they enjoyed the same video games. Terry and Troy agreed that school was "boring." If group cohesion failed to develop during this early stage, it would have been difficult to accomplish other group goals. Furthermore, it would have also been difficult for the group to progress to next stage of group development. Wickham (1993) cautions that members need to complete the tasks associated with each stage in order for the group to move forward. As group cohesion developed, the children shared more intimate details of their experience

with family violence. Mutual aid seemed to develop as well and group members felt comfortable challenging each other's point of views.

The importance of working with a compatible co-facilitator cannot be overstated. A co-facilitator can provide the group leader with emotional support and feedback, share responsibilities, and can assist to model different styles of interaction (Peled & Davis, 1995; Toseland & Rivas, 1998;Wickham, 1993). Although it would have been possible to have facilitated Group 2 without a co-facilitator, my role as group leader would have been more challenging and complex. Crystal provided me with constructive criticism when needed, as well as providing me a "second set of eyes and ears." There were moments in the group when I became distracted and failed to notice important group dynamics. Fortunately, Crystal was able to share what she felt was important. I further feel that co-facilitating Group 1 with Linda was also an important learning experience. Her vast experience facilitating children's groups provided me with numerous ideas for Group 2 including: using the "circle time" format for group discussions, use of a written agenda, and the importance of allowing the children to work at their own pace.

According to Peled and Davis (1995), "games and other free play can serve as a release of tension" (p. 99). Incorporating non-threatening games and activities into the sessions introduced the element of fun in our group. More importantly, these activities helped the children to after discussing their family violence experiences. On several occasions, some of the children appeared to be showing signs commonly associated with anxiety (fidgeting, restlessness, using distractions). To address this, a physical break was used to help the group members release tension.

Relaxation activities appeared to be useful for this group. Peled and Davis (1995) recommend that relaxation exercises are particularly useful when children sit for a long period of time. Three of the four children in Group 2 found this activity to be a pleasant experience. This exercise required the children to find a place in the room where they would feel most comfortable. Group members were instructed to close their eyes while a group leader read a fictional story. This activity was effective when accompanied by soft music. Following this activity, the children were told that relaxation activities can sometimes help when they are angry or feeling stressed.

Snack served an important purpose for the children in both groups. This finding is consistent with the group work literature that snack not only satisfies hunger pains but also can alleviate tension (Loosely, 1997; Peled & Davis, 1995). Rabenstein and Lehmann (2000) add that snack is a "symbol of nurturance and comfort amidst an anxiety-provoking hour and a half and a consistent and anticipated element of each of the twelve sessions" (p. 201). The children in both groups enjoyed snack and looked forward to it every week.

A number of activities that were utilized in Group 2 appeared to be counterproductive. Assigning "homework" for example, was met with some resistance. During the 2nd session, the children were given a worksheet to take home. This worksheet involved listing appropriate ways of resolving conflicts. Only one child in the group completed this assignment. I decided that assigning homework to this group would be counterproductive for various reasons including: the children are probably assigned homework from school and therefore, would not be highly motivated to do homework,

worksheets may be lost; and some of the mothers may not be motivated to help their child with this assignment. For these reasons, assigning homework was avoided.

The children in Group 2 were given 15 minutes for journalling. The purpose of this exercise was to give the children an opportunity to relax and to write about any topic they were interested in. This activity was met with some resistance. Some of the children commented that they did not know what to write about or what their interests were. I realized that providing the group with little or no guidance on what to write about was counterproductive. As a result, the children were given more guidance and clarity (e.g., asking children to respond to questions like "How did you feel when you saw your mom and dad fighting?" "What did you do when you saw your mom and dad fighting?" "What are some things you can do when you are angry at someone?"). It was also decided that responding to their journal entries would serve a therapeutic value for the children. Journalling became more enjoyable when the children were given more guidance.

As previously mentioned, recruiting potential clients for Group 2 involved faxing notices to numerous agencies including several school divisions in the city. I believe that simply sending out these notices was insufficient. Follow-up calls were made to ensure that the notices were received. One individual I spoke said that faxes are sometimes misplaced or lost in a "clutter of other mail."

Conclusion

In conclusion, this practicum implemented two time limited, closed structured groups for children exposed to parental violence. Two children's groups were compared

in this practicum report: Group 1 (part of a parent-child group program) and Group 2 (group for children only). Clinical impressions suggest that most of the children viewed their group experience positively. Two children in Group 2 inquired about the possibility of another children's group starting at EHCC and said that they would be interested in participating in this group. The mothers also noted positive changes in their children's behavior. Results from the PHCSCS also indicated that some of the children felt better about themselves following their participation in the group. Two children however, continued to have behavioral and emotional problems after their participation in the children's group. Overall, it appears that this group intervention seemed to benefit several children who had been exposed to parental violence.

CHAPTER 6

Conclusion

My involvement with the parent-child group program and the subsequent children's group was a valuable and challenging learning experience for me. Through the implementation of the two groups, I was able to accomplish the learning objectives that I established at the beginning of this practicum process.

The first objective was to gain knowledge of the impact of parental violence on children's emotional, psychological, and social development. According to the literature, children exposed to parental violence are at risk of developing emotional, behavioral, and social problems. The literature further suggests that some children show symptoms associated with Post-Traumatic Stress Disorder. The literature also suggests, however, that many children who are exposed to parental violence remain relatively unaffected by their experience.

The most valuable learning came from the children who participated in the two groups. A constant theme that emerged from the two groups is that the children had mixed feelings from witnessing parental violence. The children reported feeling scared, angry, disappointed, and sad from seeing their parents fighting. Several children also reported feeling guilty for not being able to stop their fathers from hurting their mothers.

The second objective was to gain an understanding of the theoretical and empirical literature related to the effects of exposure to parental violence. The literature suggests that a number of theories have been used to understand the impact of parental violence including systems theory, family disruption hypothesis, social learning theory, trauma theory, and a risks and protective factors model. The theoretical models

discussed in this report were chosen because it appears that these models have received significant attention in the family violence literature.

The third objective was to learn about the coping strategies employed by children exposed to parental violence. According to the literature, children resort to using either "emotion-focused strategies" or "solution-focused strategies" to cope with parental violence. The children from both groups shared some examples that were effective for them: hiding underneath a table, going to a different room, watching television, petting the dog, and going to a friend's house.

The fourth objective was to gain an understanding of the effectiveness of a group work intervention with children exposed to parental violence. The literature suggests that a group work approach can be an effective form of treatment under favorable conditions (e.g., the child has been assessed and is ready to talk about the violence, the child is comfortable in a group setting). Empirical studies also appear to support this type of treatment modality. Perhaps the most revealing is what the children shared in the client satisfaction questionnaire. In general, the children from both groups indicated that the group was fun and that being around other children who have had similar experiences made them realize that family violence "happens in other families."

The fifth objective was to develop comprehensive knowledge in recruiting clients, intake and assessment, and the application of evaluation measures. I learned that recruiting clients can be a difficult and challenging task. When recruiting potential clients, it is important to inform the community (either directly or indirectly using notices, posters etc.) well in advance. Notices should include all pertinent information regarding the program including eligibility requirements, contact persons, and group

goals. I also learned the importance of the intake session and performing a careful assessment of potential clients. The assessment is used to determine if the child is ready to talk about the violence and to determine if a group work approach can benefit the child. The presence of the mother during this interview gives the child permission to talk about the violence.

This practicum gave me an opportunity to learn about the Child Behavior Checklist (Achenbach, 1991), and the Piers Harris Children's Self-Concept Scale (1984) including their strengths and weaknesses. According to the literature, these measures have strong psychometric properties and have been used with children exposed to parental violence. I learned how to administer, score, and interpret the results from these instruments. In addition, I have learned that these measures should be used to supplement other assessment tools (e.g., clinical impressions, client satisfaction questionnaire).

The sixth and final objective was to develop an understanding of the group stages of development. Prior to my involvement with the parent-child group and the children's group, I had the opportunity to co-facilitate a children's group that also dealt with parental violence. At that time, my knowledge regarding the group stages of development was very limited and therefore, I was unaware of what to expect. Since then, I have learned that it is important to be aware that treatment/task groups move through different stages of development. Knowing the particular stage the group is in provides group leaders with a sense of direction. Knowing for example, that our group was in the pre-affiliation stage made us aware that the children will engage in "small talk" in order to find a connection with one another. I was aware that the children needed

to find something in common was normal and their way of finding some sense of security within the group.

In sum, my involvement in the two children's group enabled me to accomplish the learning objectives that were established at the beginning of this practicum. Furthermore, the experience gave me an appreciation for the complexities in facilitating children's groups. I also gained valuable experience working with families and the importance of networking with others.

Recommendations

The following recommendations are made in light of the practice and learning themes that emerged from this practicum. Firstly, I agree with a number of writers (e.g., Carlson, 2000, Wilson et al., 1989) that a 12-week group intervention is too brief and not intensive enough to change children's behavior problems. Several children in both groups appeared to be show improvements in certain areas. However, some of the children continued to struggle with internalizing and externalizing behavior problems at home and at school. One recommendation is to increase the duration of these programs from 12 to 15 weeks. The additional 3 sessions could focus on activities that enhance self-esteem.

Special consideration should be given to the room where the sessions will be held. Ensuring that the room has adequate space for free play and other physical activities (Peled & Davis, 1995) is important. It is also important to consider the following:

- The contents of the room (items that could be distracting should be removed),
- Location of the room (safety reasons etc.),

- If the room has adequate lighting, and
- If the room allows for privacy.

The room utilized for Group 1 was more suited for the children. There were several benefits to this room including adequate floor space, few distracting objects, and permitted more privacy. The, disadvantage of using this room, however, was its location to the washrooms (created safety concerns).

The room used for Group 2 on the other hand, contained too many distracting objects (e.g., computer equipment, shelves containing books and other unnecessary furniture). A glass wall on one side of the room also distracted the children at times when individuals walked by. Privacy was sometimes compromised. The major benefit of using this room however was its location to other available rooms. One room was designated as the waiting room where parents and their children could wait.

Another recommendation is to make weekly calls to the mothers. As previously mentioned, these calls can be used to provide the mothers with feedback on their child's progress in the group, to find out if there were any significant events during the week that may impact their child's progress, and to answer any questions that the mothers may have regarding the group content or activities.

It is important to determine who has legal custody of the children before scheduling an intake session. Vicki, Terry's biological mother, completed all the necessary consent forms prior to the intake session. Following the intake session, Vicki informed me that her former partner had legal custody of Terry. This meant that Terry could not participate in the children's group until the consent forms were signed by his father. Fortunately, several days before the group started, his father completed and

returned the forms to EHCC. Therefore, to avoid complications, I recommend clarifying which parent has legal custody of the child.

Due to time constraints, the screening process for Group 2 involved one intake session for each family. It was difficult to "compress" everything into one session. During the intake session with the mother and child, attention was on acquiring family background information (who the family members are, if the child sees the offending parent, where the child goes to school, where the offending parent lives, etc.) and assessing the readiness of the child to participate in the group. Several minutes were spent discussing the children's group (i.e., group content, goals, and activities). In addition, the measures were administered during this session (once it was established that the child was ready to participate in the group).

A final recommendation is to establish a good rapport with the children. As an instructional assistant who has worked extensively in a variety of school settings and with different students, I have learned the importance of "connecting" with the children I will be working with. There are a number of ways to accomplishing this. First, each child must be treated with respect. Every child is unique and may have had various experiences with parental violence. It is important that each child know that he or she deserves respect. Secondly, some self-disclosure on the part of group leaders is useful. I believe that sharing some information about ourselves allows the children to see us as "more human" rather than "experts." Finally, I believe that having a sense of humour helps the children feel more comfortable and can alleviate their anxiety.

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Appendix A

Children Exposed to Parental Violence:
A Children's Group

This 12-week group treatment program is for children who have been exposed to parental violence. Group sessions will be held once per week (approx. 1 hour and 30 minutes) and will be facilitated by a male/female co-therapy team.

Discussion will focus on: Responsibility for the violence, different forms of abuse, socially appropriate ways of resolving conflict, safety issues, and expression of feelings. This group program will provide a warm and safe environment where children can have fun while they learn.

Who is Eligible?:

- Children between the ages 9-11.
- Children who have been exposed to parental violence (including violence between common-law partners).
- Children who live in a safe environment where violence is not occurring.

When?: February, 2002 (Monday evenings-6:00 p.m. to 7:30 p.m.)

Where?: Elizabeth Hill Counselling Centre
301-321 McDermot Avenue

Cost?: *There is **no fee** for this 12-week treatment program.

For more information about this group program, please contact:

Raul Dimaculangan Jr. @ 956-6560.

Appendix B

Parent Feedback Questionnaire

1. Do you feel that the group program had a positive or a negative impact on your child?

2. Have you noticed any behavioral and or attitudinal changes in your child during the last twelve weeks? If so, do you think that these changes are attributable to your child's experience in group?

3. Do you feel that the duration of the group(12 weeks) was (circle one):

1	**2**	**3**	**4**	**5**
too short	a bit short	just right	a bit too long	too long

4. Was there anything that you did not like about the group?

5. Would you recommend this type of group to a parent whose child has been exposed to family violence?

6. Please feel free to use the following space for any comments or questions you may have about the group.

Thank-you for your response

Children's Feedback Questionnaire

1. What did you like most about this group?

2. What didn't you like about this group?

3. What did you learn about family violence?

4. Do you have any ideas about how the group could be better?

5. What will you remember the most about group?

6. Do you think this group could be helpful for other kids who have seen their parents fighting?

7. Do you have any other comments or questions about the group?

Thank-you for your response

Appendix C

Congratulations

on completing the Children's Group
at Elizabeth Hill Counselling Centre.
February – April 2002

Raul Dimaculangan Jr.

Crystal Black

Appendix D

Session 1

Goals for 1st Session: Building group cohesion and trust, help children to break the silence of family violence, and seeking commonalties.

Group Content

1. Circle Time
   - Introductions
   - Members describe how they are feeling/how their week went
   - Children are informed about the purpose of the group

2. Message for this week: Orientation
   - Children brainstorm on group rules
   - Design/personalize envelopes

3. Activity Break
   - Simon Says
   - Number game

4. Snack

5. Journalling
   - Children can write or draw in their journals

6. Check out
   - What they liked about the session
   - Upcoming events in school
   - Good-bye Song

Session 2

Goals for 2nd Session: Building group cohesion and trust, creating nurturing environment

Group Content

1. Circle Time
   - Hello song
   - Members describe how they are feeling/how their week went

2. Message for this week: Good and Bad Secrets

Discuss difference between good and bad secrets
Read: Clover's Secret
Group Discussion

3. Activity Break
   I Spy
   Number game

4. Snack

5. Journalling
   Children can write or draw in their journals

6. Check out
   What they liked about the session
   Upcoming events in school
   Good-bye Song

Session 3

Goals for 3 rd Session: Increasing conflict resolution skills to enhance group cohesion

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for this week: Different kinds of feelings
   Educational video- Feelings: Glad, Mad, Sad
   Group discussion

3. Activity Break
   Worksheets- Feelings crossword puzzle, Feelings worksheet (group members paired off)

4. Snack

5. Journalling
   How did you feel when you saw your parents fighting?

6. Check out
   What they liked about the session
   Upcoming events in school
   Good-bye Song

Session 4

Goals for 4th Session: Building trust and mutual aid, expand children's vocabulary

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for this week: Different kinds of Abuse
   Discussion on different forms of abuse (physical, emotional, sexual)

3. Activity Break
   Role play- Group leaders acted out different kinds of abuse and children had to label the kind of abuse they were seeing.

4. Snack

5. Journalling
   Have you ever experienced some kind of abuse and how did you feel?

6. Check out
   What they liked about the session
   Upcoming events in school
   Good-bye Song

Session 5

Goals for 5th Session: Seeking commonalties, building cohesion

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: When Parents Fight
   Review that all the children in the group have witnessed their parents fighting
   Book: Mom and Dad are Fighting
   Discussion

3. Activity Break
   Musical Pillows
   Trust Game

4. Snack

5. Journalling
   What did you do when you saw your parents fighting?

6. Check Out
   What they liked about the session
   Upcoming events

Session 6

Goals for 6th Session: Enhancing coping and adaptation, conflict resolution

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: Anger
   Discussion about angry feelings: What is anger? What are some things people do when they are angry? What makes you angry? How do we know when we are angry (warning signs)? What are some positive ways we can deal with anger?

3. Activity Break
   Game- Who Wants to be a Good Problem Solver?

4. Snack

5. Journalling
   How do you deal with anger?

6. Check Out
   What they liked about the session
   Upcoming events

Session 7

Goals for 7th Session: Enhancing group cohesion and conflict resolution

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: Sharing Personal Experiences
   Activity-Hunting for colored cards with one of the following questions:
   Draw the most violent event you have seen in your family.
   Finish the following sentence: When I saw my mom and dad fighting, I wanted to.
   Choose the feeling you had during the violent event (feelings worksheet)
   After seeing the violent event, what made you feel better?

3. Activity Break
   Balloon Activity

4. Snack

5. Journalling
   What did you find helpful after seeing the violent event?

6. Check Out
   What they liked about the session
   Upcoming events

Session 8

Goals for 8th Session: Enhancing conflict resolution and differentiation

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: Responsibility for the Violence
   Book: Hear My Roar

3. Activity Break
   Relaxation Activity

4. Snack

5. Journalling
   Write or draw about the violent event and label the person responsible for the violence.

6. Check Out
   What they liked about the session
   Upcoming events

Session 9

Goals for 9th Session: Building trust and mutual aid

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: It's O.K. to Have Mixed Feelings
   Book: Will Dad Ever Move Back Home?

3. Activity Break
   Candy Hunt

4. Snack

5. Journalling
   3 Wishes worksheet

6. Check Out
   What they liked about the session
   Upcoming events

Session 10

Goals for 10th Session: Increasing coping, adaptation, and conflict resolution, raise termination issues.

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: I Have the Right to be Safe
   Worksheet-"Safety Plan"

3. Activity Break
   I Spy, Taste Test

4. Snack

5. Journalling
   Write down any questions you may have about today's session or any of the sessions.

6. Check Out
   What they liked about the session
   Upcoming events

Session 11

Goals for 11th Session: Increase self-esteem and self-worth

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: What I Like about Myself
   Define self-esteem and self-worth

3. Activity Break
   Guess what's in the bag

4. Snack

5. Journalling
   How do you feel about the group ending?

6. Check Out
   What they liked about the session
   Upcoming events

Session 12

Goals for 12th Session: Raise termination issues, help members separate from the group.

Group Content

1. Circle Time
   Hello song
   Members describe how they are feeling/how their week went

2. Message for This Week: Review of weekly themes
   Discussed what was learned during the twelve weeks

3. Certificates/ farewell cards handed out,

4. Activity Break
   Last session Party

5. Check Out
   What they liked about the session
   How they feel about the group ending