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MORE ON THE YO-YO CHILDREN: A DEMONSTRATION PROJECT OF GROUP WORK WITH CHILDREN WHO HAVE BEEN EXPOSED TO FAMILY VIOLENCE

by

Peter Dirks

A Thesis
submitted to the
Faculty of Graduate Studies and Research
through the Department of
Social Work in Partial Fulfillment
of the requirements for the Degree
of Master of Social Work at
the University of Windsor

Windsor, Ontario, Canada

1987

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ABSTRACT

More on the Yo-Yo Children:
A Demonstration Project
of Group Work with Children
who have been exposed
to Family Violence

The objective of the project was to develop and test the effectiveness of a group intervention program for children from violent homes. Practice with groups can be an effective means of helping these children to cope with their emotional and physical responses to the crisis they have experienced as a result of having been witnesses to parental violence.

Intervention was based on factors that relate to the effects of witnessing violence and factors that relate to research on how children have coped with a variety of different family and life situations. The proposed intervention model and procedures emphasized competence enhancement rather than treatment of specific behaviour or

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emotional problems, since the children were involved as a result of the behaviour of the parents rather than their own behaviour.

It was hypothesized that children who have been exposed to family violence would show improvements in cognitive and behavioural skills following group treatment, compared to no treatment comparison subjects. In addition, a measure of child adjustment and mother's report would reflect improvements in the conduct of the child.

The study subjects were twenty-eight children who have been exposed to marital violence in their homes. Children were non-randomly assigned to either a treatment group or a comparison group. There were two treatment groups, one for children aged seven to ten and another for children aged eleven to thirteen, as well as corresponding comparison groups. Measures were utilized in the pre-group and post-group situation to determine the effectiveness of group intervention.

Results obtained from this research showed that the difficulties faced by children from violent homes were not uni-dimensional, but complex, in which a multiple of factors

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play a part. Children from violent families have faced and continue to face not only the negative impacts of familial violence, but also the impacts of associated stressors which are present in violent families. The data generated from this study has suggested that social work with groups can be an effective means to provide support to children from homes where violence is present. The study has concluded with recommendations to help achieve the prevention of intra-spousal abuse by intervening with the children from violent homes.

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Dedicated To The Ladies Who Helped Shape My Life

Irene, Melanie, and Charlotte

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I would like to express my sincere and grateful thanks to Dr. Peter Jaffe, Dr. David Wolfe, Susan Wilson and Lydia Zak of the London Family Court Clinic for providing me with the invitation and opportunity to participate in a research study, the purpose of which was to evaluate the effectiveness of group treatment for children who have witnessed marital violence.

During the fall of 1985, and winter of 1986, one hundred and twenty five children from five Ontario communities participated in this research, funded by the Ministry of Community and Social Services. Twenty-eight children from Kent County participated in a component of the study which has become known as the "Chatham Demonstration Project".

The development of the Chatham Demonstration Project was an excellent example of how helping professionals in Kent County work together to help meet the needs of children from violent homes. Special acknowledgement must be given to Joy Pyymaki, Director of the Chatham-Kent Women's Centre and Julie Farrell, Executive Director of the Lester B. Pearson Centre for Children and Youth, who offered the use of their facilities and the services of their staff in co-ordinating

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the development of the first children's treatment groups for children from violent homes in Kent County. A further thanks is extended to the workers of the Children's Aid Society of the County of Kent, Chatham-Kent Community and Family Services, and the Kent County Task Force on Family Violence, who along with the Chatham-Kent Women's Centre and the Lester B. Pearson Centre contacted families and provided referrals to the children's groups.

Much of the credit for the success of the first groups for children from violent homes in Kent County must be given to the therapists who worked very hard in their preparation and running of the groups. My heartful thanks go to Bill McIntosh, group social worker from Children's Hospital of Western Ontario; Susan Wright, group social worker from the Lester B. Pearson Centre; and Karen Sanchuck, child care worker from the Chatham-Kent Women's Centre; all of whom shared responsibility for providing group work services to both treatment groups during the fall of 1985. In addition, Susan Wright and Karen Sanchuck co-led the treatment groups during the winter of 1986 when treatment group work services were offered to comparison group children.

I am also grateful to Professor Robert Chandler, Chairman of my Thesis Committee, for his guidance, support

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and encouragement in the undertaking of this research. My gratitude also goes to Dr. L. E. Buckley and Dr. S.A. Selby for all the time and effort they have spent on this research project.

My deepest thanks goes to the members of my family who have provided so much support and encouragement during the past months. In particular, I would like to thank my wife, Irene, my daughter, Melanie, and my mother, Charlotte.

Most important, the participation of the children and their mothers must be recognized. Both the children and their parents showed a great deal of courage and willingness to risk of themselves, by participating in a project which examined one of the most painful aspects of family life - family violence and its impact on the families' children. Without the children's and their mothers' willingness to share information about themselves, this research project would not have been possible.

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CHAPTER 1

INTRODUCTION

Family violence has emerged as a major social problem in the 1980's as a function of government hearings, media attention and research efforts. Such behaviour has required social workers to become more aware of all forms of violence in the present and past family life of these clients. Both research and clinical experience have supported the notion that "violence begets violence". Not only has family violence produced many of today's clients in children's mental health centres and women's shelters, but also tomorrow's abusive husbands, as well as battered wives and children. It can be argued that prevention of family violence and its physical and psychological consequences must start with professional attention to the special needs of children from violent families.

1.1. PURPOSE

This research proposal will extend previous findings of children who have been exposed to violence between their

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parents, by describing and evaluating a group intervention program for young children in this high-risk violent population. The second purpose is to demonstrate that social work practice with children in groups can be an effective means of helping them cope with their emotional and physical responses to the crisis they experience as a result of having been witnesses to parental violence.

It was hypothesized that children who have been exposed to family violence will show improvements in cognitive and behavioural skills following group treatment, as compared to those who receive no treatment. In addition, a broad spectrum of child adjustment and mother's report will reflect improvements in child conduct. Subjects in the present study were 28 children who have been exposed to family violence in their homes within the past year. Children were non-randomly assigned to one of two groups; a treatment or comparison group. Measures were utilized in the pre-group and post-group situation to evaluate and determine the effectiveness of group intervention.

1.2. RELEVANCE TO SOCIAL WORK

This study is relevant to social work with the child and family in that it addressed adjustment difficulties faced by

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the child who has witnessed and/or experienced parental violence. As well, it has looked at prevention of future difficulties these children might experience as single adults or as parents in their own families of the future. The intervention has focused on factors that relate to the effects of witnessing violence, e.g. conflict resolution skills, problem solving, attitudes towards violence, coping skills, and factors that relate to the available research on how children cope with a variety of difficult family and life situations. These included the availability of social supports and relationships with parents and other adults. Since the children were involved due to the behaviour of their parents, rather than their own behaviour, the proposed intervention model and procedures have emphasized competence enhancement rather than the treatment of specific behaviours or emotional problems.

Social workers must recognize that any child who lives with violence, or the threat of violence, can be considered a child in need of protection due to the following:

- a man who abuses his wife may also abuse his children
- a woman who is abused may vent her anger and frustration on her children. In turn, the children may vent their own rage and frustration on each other

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or on themselves

- children may be accidently hurt when they try to stop the violence or attempt to protect their mother,
- children witnessing parent assault in their home may grow up to be abusive husbands or assaulted wives.

Even if children have not been the direct target of the violence, their mere exposure to violence may leave them to suffer from tremendous emotional abuse and possible neglect (Sinclair, 1985, p. 85).

Children from violent homes seldom have an adequate relationship with their fathers. Although many children living with the threat of violence are close to their mothers, the mothers cannot be fully available to tend to the children's needs when they are forced to fight for their own survival on a daily basis. This is not said to fault mothers. Many have done quite incredible jobs of raising children in the face of horrendous odds. However, the only way to end the generational cycle of abuse is to stop it today.

In addition, social workers need to recognize that children need the same kind of support and advocacy that their parents need. In the past, the focus has been to

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supply services to the abused women and the batterer. It was hoped that the benefits of providing services and treatment for the parents would have a "trickle down" effect. As a result, group work with children in abusing families has still been a relatively new area. There is no specific group model for children and this research is intended to help fill some of that void.

Group work with children can help the child face, and deal with, his or her own anger as well as see the alternatives to violence and helplessness that are available. Other issues that can be addressed with children are ambivalence, role expectations, expression of feelings, and the development of appropriate self responsibility.

Regardless of the practice setting, the social worker must consider himself or herself to be part of a network of services. The violent family and its individual members require flexibility and often have multiple needs; therefore, working relationships among agencies should be fostered. For example, the social worker must feel comfortable making a referral to a children's protective service agency if child abuse, or neglect, is indeed evident or suspected.

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Because violence in the family is to some extent a reflection of, and response to, factors within the social system, the social worker must be cognizant of the socio-economic and cultural factors that have contributed to stresses within the family, as well as the family's reaction to external factors. Documentation of what has happened to families and their children, as well as educating the public and its decision makers, are contributions the social worker can make toward the changes necessary to support and promote healthier family functioning.

This research is also relevant to social work with the child and family since current statistics show that every year, one out of every ten wives is physically abused by her husband (MacLeod, 1980). This also recognizes that thousands of children from these violent homes are involved as well. The fact that a growing number of children have experienced violence in their home has staggering implications for future generations and for the social work profession.

A violent home situation may signify the disruption of a familiar life style, a change of roles, a change in social identity and a change in actual functions. The violence alters the family emotional network. The emotional

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processes that result from a violent home situation and its effects may continue far into the future. Social workers continued commitment to preventive intervention, treatment and enhancement in social work practice with the child and family should insure their involvement in the needs of this particular population.

1.3. RATIONALE FOR DEVELOPING AN INTERVENTION STRATEGY FOR CHILDREN FROM VIOLENT HOMES

The growing awareness of how exposure to wife battering may affect children has not been matched by the development of specialized programs for these children (Jaffe, Wolfe, Wilson, Slusczarzck, 1986). A survey of Canadian shelters for battered women revealed that only a small minority had any specialized staff or programs available for the children who accompany their mothers to these centres (National Clearinghouse on Family Violence, 1984). Most of the centres have recognized the children's needs but indicated a lack of secure funding, space, or support of other community agencies to develop the needed programs.

Children of battered women are at risk for a number of behavioural and emotional disorders, yet they have received disproportionately few mental health services (Rosenbaum &

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O'Leary, 1981). This failure to provide needed assistance for victims of family violence may be due to our poor understanding of a child's adaptational capacity following stressful life experiences, especially those events that involve other close family members (Jaffe, Wolfe, Wilson & Zak, 1985). Adjustment problems shown among traumatized children can be highly variable and delayed, or both, in expression, which is believed to be a partial function of the child's temperament, social supports, and acquired skills (Garmezy & Rutter, 1983). Among children from violent families in particular, research studies have begun to identify a number of early indicators of maladjustment (Wolfe, Zak, Wilson & Jaffe, 1986) that increase the probability of later developmental psychopathology. Unfortunately, the common approach to assisting these children has been almost entirely limited to preventing the recurrence of violence through the removal of the child or the perpetrator. Paradoxically, actions to protect the child may unintentionally have contributed to his or her maladjustment unless additional assistance is provided for the child's recovery. For example, following the discovery of wife battering, the child was commonly subjected to rapid intrusions in his, or her, routine and circumstances that can be highly disruptive. Because family resources are often impaired, the child may be incapable of adapting to

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these rapid changes without carefully planned assistance.

Although major references (Straus, Gelles & Steinmetz, 1980) and governmental reports (Federal, Provincial, Territorial Report on Wife Battering, 1984) in this field end with a plea for prevention efforts, there were few specific programs for children from abusive families. General suggestions have been offered for eliminating the underlying causes of family violence (Straus, 1983) or providing family violence prevention courses in all school systems (Standing Committee on Health, Welfare & Social Affairs, 1982); however, the vast majority of programs have focused on the adult need rather than those of the children. For example, treatment programs for spouse abuse have often ignored the child's considerable needs for current support and problem solving assistance, which often increase dramatically once the violence has been discovered and community agencies are involved with the family (Alissi & Hearn, 1984).

In designing intervention strategies for children who are victims of family violence, one needs to take into consideration a developmental perspective of cognitive and behavioural factors that are related to the etiology of family violence, as well as those issues that may be

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important in helping children recover from turmoil. A strategy that has built on these factors, in the context of a child's individual response to witnessing violence, such as the teaching of coping skills, should be helpful to any clinical population (Rutter, 1983).

The lessons that children are likely to learn from violent parents (to the extent that they identify with their parents and model this behaviour) can be formulated:

- violence is an appropriate form of conflict resolution
- violence has a place within the family interaction
- if violence is reported to others in the community, including mental health and criminal justice professionals, there are few, if any positive results
- sexism, as defined by an inequality of power, decision-making, and roles within a family is to be encouraged
- violence is an appropriate means of stress management,
- victims of violence are expected to tolerate this behaviour at best, and to examine their responsibility in bringing on the violence, at worst.

After exposure to these events, children of violent parents may learn to be assailants or victims. Moreover,

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the child's learned patterns of social behaviour can be observed in his or her inappropriate social skill development, as well as attitudes that promote family conflict (Carlson, 1984).

Another direction for developing an intervention strategy has profited from research focusing on children's coping or adaptation engendered by stressful life events. There is evidence that what constitutes a stressful life event for a child is different from that of an adult. The adaptational process may be influenced by such factors as the child's age and sex, coping style, and the responsiveness of environmental factors such as social support or family organization (Felner, 1984; Rutter, 1983). Recent empirical evidence from studies of children undergoing stressful life experiences (e.g., divorce, medical procedures, and family crises) has indicated that the immediate stress associated with the crisis, or trauma, may be less significant than changes and stressors in the child's social environment associated with the event (Felner, 1984). For example, recent studies have shown that the reestablishment of stable, predictable patterns of family functioning and routine may greatly enhance a child's adaptation to parental divorce (Heatherington, Cox & Cox, 1979) or serious illness (Koocher & O'Malley, 1981).

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Therefore, it may be argued that the child's competencies and resources assume a central role in determining the adaptive outcome achieved, rather than the type of stress per se. The perspective taken in this research emphasizes the child's active problem solving skills that lead to the reorganization and modification of important stress mediators, such as social supports, daily routines, interactions with parents, and peer activity (Felner, 1984).

Methods for acquiring the active skills needed for mastering the changes and tasks that accompany stressful events have begun to receive greater attention in recent years. Rather than focusing upon specific target behaviours or internal psychodynamics, what has emerged as a promising strategy has been an emphasis upon adaptive thinking processes or interpersonal problem solving, that can be taught to children (Jaffe, Wolfe, Wilson, & Zak, 1985). This strategy defines several training components, such as perspective-taking, modeling, reinforcement, and behaviour rehearsal that have generally been successful with non-clinical samples (Urbain & Kendall, 1980). Teaching problem solving skills to children has indicated that they can learn to identify problem situations and generate alternative responses with a careful consideration of the consequences of their behaviour (Shure & Spivak, 1976). At present,

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however, the utility of such an approach for improving problem solving skills in children from abusive families has not been demonstrated or attempted. Possibly this approach could be well-suited as a preventative strategy for children who are experiencing stressful life circumstances, in contrast to a unidimensional treatment method for serious childhood disturbances (Urbain & Kendall, 1980). Due to its emphasis upon interpersonal situations, attitude change, perspective-taking, and behaviour rehearsal of specific tasks, a problem solving approach, that is geared specifically to the recovery needs of children exposed to family violence, should be effective.

This research has focused on children's attitudes about aggression and family behaviour, as well as skills for resolving interpersonal problems. Emphasis was placed on methods that were sensitive to the child's developmental level and needs. It was also believed that children can more effectively learn to identify problem situations and generate alternative responses when offered a careful consideration of the consequences of their behaviour. However, it has remained a real challenge to improve problem solving skills in children who have witnessed marital violence, because their parents have demonstrated the very opposite behaviour.

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Finally, from the group work literature on children of divorce, both Cantor (1977) and Effron (1980) have found short-term group work to be an excellent vehicle to help elementary school children who were attempting to cope with the stress of their parents' divorce. This suggested that use of groups might be an effective vehicle for children who have witnessed family violence, since both groups have some emotional issues in common.

1.4. OBJECTIVES OF THIS STUDY

Based on the needs expressed previously, the following objectives were formulated:

- to develop a social work group treatment strategy, for children who have witnessed family violence, that can be replicated by other professionals working in this area
- to test the effectiveness of the group intervention program developed for children from violent homes
- to help fill a void which presently exists in the family violence literature with respect to treatment of children from violent families.

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1.5. SUMMARY

The goal of this introductory chapter was to present the purpose and primary hypothesis tested in this research. In addition, the chapter has discussed the relevance of this research study to the social work profession, as well as the rationale for developing an intervention strategy for children, and objectives of the study.

The second chapter summarizes the literature currently available in professional journals, scholarly textbooks, and government publications which suggest how interspousal violence impacts on children. Since the study encompassed children aged seven through thirteen, the literature review includes discussions on the developmental concerns of both latency aged and early adolescent children. Also included in the literature review are sections dealing with the extent of intra-spousal violence, evidence to support the intergenerational transmission of violence, and social learning theory which provides theoretical constructs that violence is a learned behaviour. The second chapter also documents the multi-dimensional stressors which have been found to impact negatively on children from violent homes and the treatment issues that arise from witnessing parental violence. Finally, the chapter presents the theoretical

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rationale for choosing group work as a method of intervention with children from violent homes, as well as information about the developmental group work models utilized in the past and present when working with children.

The third chapter deals with the methodology utilized in this research. There are sections devoted to the historical beginnings and development of the Chatham demonstration project, the experimental design chosen for the study, the population being researched, the statement of the primary hypothesis and sub-hypotheses being tested, and the operational definitions which guided this research. Information has also been provided about the instruments chosen to conduct the pre and post-treatment interviews, and the statistical analysis utilized in this research project. A section on the limitations of the study is also presented. Finally, the group work model used in the research, as well as the content of group sessions are addressed.

The fourth chapter reports the findings of the research project. This includes both descriptive findings, as well as data tested for statistical significance. These findings are interpreted in terms of what was already known about the impact of violence on the children and tentative conclusions are discussed. Data collected from the mothers of the

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children and the children themselves are presented.

The final chapter reports a summary of the findings and conclusions reached. The chapter offers recommendations for future research and suggests helpful interventions in dealing with children from violent homes for other helping professionals and the public at large.

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Chapter 2

LITERATURE REVIEW

2.1. DEVELOPMENTAL CONCERNS IN LATENCY AGED AND EARLY ADOLESCENT CHILDREN

This study has included children aged seven through thirteen years of age. Thus, this research encompassed children who were passing through two phases of life cycle development. These developmental phases have been identified by researchers as being the latency-aged years and early adolescent years.

The school age years of childhood include a developmental stage of the life-cycle of the child which Freud has called "latency" (Archer, 1985). Essentially, "latency" has been defined as "a period of rest from sexual tensions that have influenced the child during the Oedipal phase of development and that will re-emerge during adolescence" (Franke, 1983, p. 89).

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Wallerstein & Kelly (1976) classified this developmental stage in two sub-groups, grouping six to eight year olds in "early latency" and nine to twelve year olds in "late latency". However, there has been some disagreement among researchers as to the specific age limits of this developmental stage (Archer, 1985). While Musetto (1982) identified latency with the ages six to nine years, Kurdek & Sieskey (1978) and Smart & Smart (1967) included ages six to ten as being the latency years. For purposes of this research, latency aged children included those children between the ages of seven through ten.

Briggs (1970) described the latency stage as the period during which the child is bearing down on the "homework of self". During these years, the child experiences remarkable cognitive growth and starts to move from concrete operations to inductive logic. Also, during these years, the child starts to make attachments with others outside his family and individual friends become important. The child starts to learn new ways of interacting and playing with others, and thus grows in his own independence (Briggs, 1970; Elkind & Weiner, 1978; Bee, 1981).

Summarizing, the primary tasks of latency then, are to "develop the repertoire of abilities society demands" (Bee,

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1981, p. 319) and to "define his person from reflections outside the family" (Briggs, 1970, p. 139). Successful completion of developmental tasks lays the cornerstones for future adaptive functioning. If the child is unsuccessful at these tasks, he will develop a "sense of inferiority" or "lack of worthiness" (Briggs, 1970) rather than a "sense of industry" (Erikson, 1968, p. 123).

The early adolescent years are characterized by certain developmental tasks which the child needs to master (Meredith, 1967). Successful passage through the early adolescent period is dependent on the adaptation the child has made to the changes which have occurred. Psychological, cognitive and social changes accompany the physical maturation which is associated with the onset of puberty. According to the Freuds (Freud, S, 1938; Freud, A., 1958) physiological changes at puberty prompt stronger and more urgent sexual feelings than those experienced prior to their onset. Since these growing sexual feelings cannot be directed towards the parents as primary love, gratification is sought outside the family and the child starts to seek the approval of his peers and achieve greater independence from his parents. Successful completion of this task of socialization is enhanced by a child's acquisition of a sexual and ego identity. The peer group helps the

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adolescent to accomplish the following tasks:

- achieving mature relations with age mates of both sexes
- adopting a masculine or feminine role
- achieving emotional independence from parents
- desiring and achieving socially responsible behaviour
- acquiring a set of values and an ethical system as a guide to behaviour (Bernard, 1971, p. 208).

Erikson (1968) has claimed that the acquisition of an ego identity is the major task of adolescence. This process begins in early adolescence and successful completion is indicated when the child has achieved the integration of the adolescent's ambitions and aspirations with the previous identifications acquired in the earlier stages (Muss, 1962).

Another developmental task associated with early adolescence is referred to as the task of cognitive development (Piaget, 1973). Successful completion of this task is measured by the child's ability to move from concrete to abstract reasoning. Abstract reasoning is often identified as capacity for adult thinking (Campbell, 1976).

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The key tasks of early adolescence can then be characterized as the formation of:

- the development of a sexual identity
- the continued development of an "ego" identity and movement away from family members
- movement to a focus on "peer relationships", and
- the continued cognitive development signified by completing the movement from concrete to abstract thinking.

To children, their parent's positive attitude toward them can be considered of crucial importance when children are forming their own self-concept (McCooby, 1980). "Children who cannot enjoy being at home or around their families may be severely handicapped in their social development" (Elkind & Weiner, 1978, p. 438). Parents promote their children's physical, social competency, and self-esteem when they:

- are committed to their child's welfare and are responsive to their needs
- create structure with a predictable environment
- offer opportunities for developing skills
- allow the child a role in family decision making

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compatible with family functioning

- listen to the child's point of view and explain parental actions in a way he understands
- allow the child to solve his own problems whenever possible
- show affection,
- avoid making the child feel guilty for separating from the family. (Briggs, 1970; McCooby, 1980)

It can be argued that interspousal violence interferes with the family's ability to fulfill its functions. As a result, the family living with violence or the imminent threat of violence may be unable to promote the continuing development of each of its members. Children from these families may be expected to experience both short-term and long-term adjustment difficulties (Jaffe, Wolfe, Wilson, & Zak, 1986).

2.2. EXTENT OF THE PROBLEM

Family violence is a growing problem facing today's society. A study by Steinmetz (1977) revealed that verbal aggression was used to resolve conflicts in nearly all of the 78 families studied. Physical aggression was used in approximately 70% of the families to resolve parent-child

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and sibling conflict, and in 30% of the families to resolve husband-wife conflict (Steinmetz, 1977). These findings have tended to support Malinowski's observation (cited in Steinmetz, 1977) that "aggression, like charity begins at home". But a nonviolent image of the family is prevalent in our society, causing a "perceptual blackout" of the daily violence going on behind the closed doors of seemingly "normal" families (Gelles, 1974).

In Canada, it has been estimated that one in ten women, constituting approximately 500,000 women, is battered by their partner every year (Canadian Advisory Council on the Status of Women, 1980). During an 8 week period in 1977, it was determined that 11% of all police occurrences in the Region of Waterloo were domestic in nature (Waterloo Region Family Violence Committee, 1983). Much more staggering was the estimate suggesting that approximately 75% of the victims of spousal abuse never even come to the attention of the police or the courts (Waterloo Region Family Violence Committee, 1983). Wife battering is rarely a "one-shot deal"; the Canadian Advisory Council on the Status of Women (1980) reported that one-third of the women surveyed were beaten weekly or daily. The frequency and intensity of physical assaults were found to vary with the assaulter and the situation (Star, 1980).

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Slapping, punching with fists, biting, scratching, throwing down and kicking were prevalent, with breasts and faces the most frequently cited target areas (Hilberman & Munson, 1978). Sexual assault and marital rape were not uncommon in a sample of 60 battered women studied by Hilberman & Munson (1978). The most frequent result of family disputes was physical injury, with victims suffering multiple bruises, black eyes, fractured bones, subdural hematomas, detached retinas, miscarriages, permanent disability, and even death (Hilberman & Munson, 1978; Canadian Advisory Council on the Status of Women, 1980). These have not even begun to touch upon the more subtle, yet equally devastating instances of psychological and emotional abuse and neglect.

Family violence was not evenly distributed among family members but was disproportionately directed toward women (Dobash & Dobash, 1979). Considering all cases of spousal abuse, it was estimated that only 5% of the victims were men while the remaining 95% were women (Greenland, 1980). Women tended to tolerate a great deal of victimization at the hands of their partners before resorting to counterviolence (Straus, 1980).

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Star (1980) suggested that a high baseline tolerance for violence existed in North American society and that this tolerance was generalized to the family setting, legitimizing violence between family members. Family members have used force, or threatened to use force when resolving disagreements, with little or no censure by other family members (Star, 1980). "Inflicting pain is considered a 'right' of violent family members and becomes the norm rather than a deviant act. It is the first, not the last, resort" (Star, 1980, p. 344).

Societal norms that have legitimized the use of force as an appropriate response for men and submission to force as female-appropriate behaviour is fundamental to understanding the high rate of marital violence. "Society teaches women to be passive in the face of violence; many battered women are encouraged to continue their relationship even when there is no reason to believe that the situation will change" (Standing Committee on Health, Welfare and Social Affairs, 1982, p. 17). A double standard clearly exists, however. Whereas pushing and shoving would constitute an assault if the perpetrator were a stranger, these same behaviours within the marital context were seen as permissible (Hilberman, 1980). "Men who would not dream of hitting a woman, hit their wives" (Straus, 1980, p. 691).

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And yet, the victims tended to blame themselves for the violent encounter, believing that their actions somehow provoked or justified the assault (Star, 1980). They were anxious and agitated, living in constant fear of the next assault (Hilberman & Munson, 1978). Hilberman and Munson (1978) characterized the 60 battered women they studied as overwhelmingly passive, unable to act even on their own behalf. These women felt drained, fatigued and numb, often lacking the energy required to do even minimal household chores and child care. They experienced a pervasive sense of hopelessness and despair about themselves and their lives, seeing no options and feeling powerless to make changes. All in all, these battered women saw themselves as incompetant, unworthy and unlovable. When these women were overtly aggressive, it was most frequently turned against themselves (i.e. suicidal behaviour; self-mutilation; alcoholism; depression).

But one may ask about the children who are raised in homes characterized by violence and victimization. Most of the reported battered wives in Canada were under age 40 and were caring for young children (Paltiel, 1981). Eighty-six percent of the women studied by Carlson (1977) had children; the average number of children per respondent was 2.23.

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Forty-five percent of these children were five years of age or younger, 42% were 6-15 years of age, and 13% were 16 years of age or older (Carlson, 1977). Hilberman and Munson (1978) found that spouse assaults tended to occur at night and on weekends, when children were at home to witness the violence. Women in their study were described as being beaten and raped in front of the children.

In _Wife Battering in Canada_, MacLeod (1980) stated that almost half of all battering occurred between 5 p.m. and 12 midnight, 15% to 20% between 12 and 7 a.m., half the incidents occurred on the weekends and most occurred in the family home. All prime times and locations involved the children. According to Gelles (1974) the usual bystanders to conjugal violence were the children. When violence occurred during dinner-time or early evening, the children were either present or in the house. Older children were sometimes called as witnesses and even intervened in violent incidents that occurred later in the evening. Dobash and Dobash (1979) reported that over 75% of the women in their study said that the children were usually present during an assault and in some families children were always called as witnesses in order to further degrade the women. Therefore, there appears to be ample opportunity for a child to learn violent behaviour as a form of problem solving in a violent

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home.

Often these children have experienced years of violence, so much a part of their homelife that life simply goes on again after the violent incident as if nothing out of the ordinary had occurred (Sopp-Gilson, 1980). These children have been described as "yo-yo" children because of the unremitting pattern of restlessness and violence (Moore, 1975). Due to the parents' inability to resolve their difficulties in any rational way, the husband threatens or beats his wife. The spouse leaves, taking one or more of the children with her, only to return a few hours or weeks later. Thus, just as life begins to settle down for the children, the cycle begins again (Moore, 1975).

2.3. IMPACT OF FAMILY VIOLENCE ON CHILDREN

> "The witnessing children are the most pathetic victims of conjugal crime because their childhood condition will colour their entire lives. All other input will be processed through the mire of the first marriage they ever saw and the earliest models of husband, wife, mother and father" (Davidson, 1978, p. 116).

A report submitted to the National Society for the Prevention of Cruelty to Children in England indicated that in 80% of the 23 violent marital cases studied, researchers

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felt that the children had been adversely affected (Moore, 1975). The effects upon the children were divided into four categories: scapegoating, whereby the child favoured by one partner is openly rejected or even physically or verbally attacked by the other; aggression directed inward (i.e. the appearance, or exacerbation of psychosomatic complaints when parental violence occurs or escalates); school problems (i.e. many of the children were described as backward or underachievers, some even seldomly attending school); and children used as pawns by the parents in their attempts to punish each other (i.e. parents threaten to harm the children in order to get the absent parent to return home).

Levine (1975) studied 50 families in which it was known that interparental violence occurred. He found exposure to spouse abuse to be associated with truancy (approximately 36% of the school age children in his survey were persistent truants), aggressive behaviour directed against property and individuals (both at home and at school), and anxiety disorders such as worrying, anxiety, specific fears and phobias (anxiety disorders were apparent for 18.8% of the children involved).

Behaviour, systems, and psychodynamic therapists have all isolated marital discord as one determinant and/or

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maintainer of childhood problems (Porter & O'Leary, 1980). A substantial body of research suggests that there is some relationship between the incidence of marital discord and the existence of behaviour problems in children (Johnson & Lobitz, 1974; Oltmans, Brodwich, & O'Leary, 1977; Porter & O'Leary, 1980). Oltmans et al. (1977) for example, found significant relationships between marital discord and behaviour problems, personality problems and inadequacy-immaturity in children. One might suspect the findings to be even more pronounced with regard to overt marital hostility. Little systematic research, however, has been conducted looking specifically at the effects of exposure to marital violence on children.

Hilberman and Munson (1978) found somatic, behavioural and psychological dysfunctions for a third of the 209 children they studied, and it was suspected for many more. Psychosomatic illness and symptoms were prominent, especially among the females. Somatic complaints, enuresis, school phobias, insomnia and an intense fear of going to bed at night were noted for the preschool and young school children. Hilberman and Munson (1978) suggested that the children's resistance around going to bed could be time-related in that much of the spouse abuse occurred after the children were put to bed for the night. Impaired

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concentration spans and difficulty with school work were also reported for most of the children studied. Older children, on the other hand, began to show differential behaviour patterns that divided along gender lines. The most frequently reported cluster for boys - aggressive disruptive behaviour, stealing, temper tantrums, truancy, and fighting with siblings and schoolmates - was notably absent in girls. In contrast, teenage girls continued to have an increasing array of somatic symptoms and became withdrawn, passive, clinging and anxious.

Rosenbaum and O'Leary (1981) found that although statistical analysis failed to reveal significant between-group differences, male children of abused wives were found to be more likely to exhibit conduct and personality problems than were controls. The investigators concluded that children of maritally-violent couples may be particularly susceptible to the development of behavioural and emotional problems for several reasons: they are exposed to marital discord as well as to spouse abuse; they are exposed to role-models who are violent and who tolerate violence; they must cope with the fear of injury to their mother as well as possible injury to themselves; and they may be abused by either or both parents.

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Porter & O'Leary (1980) found that overt marital hostility correlated significantly with behaviour problems in boys ranging in age from five to sixteen. No significant associations, however, were found between overt marital hostility and problem behaviours in girls. The researchers suggested that both males and females are exposed to similar amounts of conflict, but that girls may be more capable of coping with marital distress than are boys.

2.4. INTERGENERATIONAL TRANSMISSION OF VIOLENCE

Exposure to marital violence may have an immediate behavioural or emotional impact on the children, but it may also have more long-term consequences, with children of maritally violent couples maturing into the next generation of abusive husbands and abused wives (Rosenbaum & O'Leary, 1981). In addition, according to Straus, sons who witnessed their father's violence have a 1,000% greater rate of wife abuse than boys of non-violent parents (Straus, Gelles & Steinmetz, 1980).

Retrospective studies have demonstrated a high frequency of violence in the families of origin of both spouses involved in abusive relationships (Rosenbaum & O'Leary, 1981). Carlson (1977) reported that approximately 33% of

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the victims in her study had witnessed parental spouse abuse as children while one-half of the assailants had observed similar violent behaviour. Scott (1974) also observed a pattern of passive mothers and violent fathers in families of origin. A survey conducted by Petersen (1980) revealed that women who were exposed to marital violence reported three times as much abuse as women who grew up in homes where spouse abuse did not occur.

Life-long violence including parental spouse abuse (usually the father assaulting the mother), paternal alcoholism and physical and/or sexual abuse as children was the pattern for one-half of the 60 battered women studied by Hilberman and Munson (1978). Most of the women left home at an early age to escape from the violence, only to find themselves married to alcoholic, battering husbands, thus replicating exactly their premarital situation (Hilberman & Munson, 1978). Rosenbaum and O'Leary (1981), however, found somewhat different results; namely, that abused wives were no more likely to have witnessed parental spouse abuse than were wives in the nonabused control groups.

While findings in support of intergenerational transmission of violence were dramatic, by no means was this always the case. For two-thirds of the couples where the

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wife was violently assaulted, however, physical violence was a behaviour learned by one or both mates in their families of origin (Petersen, 1980).

Observational learning theory may provide some valuable insight into the intergenerational transmission of violence and victimization. Bandura, Ross & Ross (1961) demonstrated that children exposed to aggressive models were not only significantly more aggressive in their play than the children in the two control groups, but they directly imitated a good deal of the novel aggressive play patterns (both physical and verbal) exhibited by the model. Observing adults behave aggressively not only permitted the learning of aggressive responses but also conveyed a certain degree of permissiveness for aggressive behaviour (Bandura et al., 1961).

Although the influence of aggressive models in experimental laboratory studies cannot be denied, exposure to parental violence may be predicted to produce even more powerful reactions in viewers, effects perhaps more likely to carry over into adulthood (Carroll, 1977). "...In new situations where a child is at a loss for what to do he is likely to remember what he saw his parents do and behave accordingly, even occasionally to his own detriment"

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(Singer, 1971, p. 31). When men and women marry and were "faced with the novelty of the role they often reverted to the type behaviour they saw their parents engage in when they were children..." (Singer, 1971, p. 31).

Thus, the maritally violent family of origin has served as a training ground for future violent behaviour (Gelles & Straus, 1975). The husband may provide a violent role-model for the male child (Rosenbeam & O'Leary, 1981), which has reinforced attitudes that approved of violence against women and provided a model for defining wives as appropriate victims of violent assaults (Ulbrich & Huber, 1981). Similarly, observing parental spouse abuse may have caused the female child to perceive violence toward women as normative and legitimate (Rosenbaum & O'Leary, 1981). Observing and experiencing violence has provided a powerful learning situation in that such experience provided the entire "script" for behaviour (i.e. the specific types of situations in which violence is used; the appropriate response to such situations; the appropriate affective states) (Owens & Straus, 1975).

Carlson (1977) found that women who had been exposed to violence as children, either as observers or recipients, were more likely to remain in an abusing relationship.

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Gentry and Eddy (1980) suggested that one reason why a large number of abused women return to the same spouse or go to another violent partner may be related to their learned expectations regarding a violent family life style. Exposure to parental spouse abuse at a young age may have desensitized girls to its effects and may lead them to expect violent behaviour in a marital relationship (Carlson, 1977). The belief system a battered woman will use to explain to herself why the beating happened was that violence is normal: "My mother got beaten, so I got beaten" (Hart & Liutkus, 1983). As a result of these rationalizations, the acceptance of battering is perpetuated from one generation to the next (Hart & Liutkus, 1983).

Parker and Schumacher (1977) reported that "if the mother in the wife's family of origin was a victim of the Battered Wife Syndrome, there was a statisticaly significant probability that the wife would be battered by her husband " (Parker & Schumacher, 1977, p. 760). In contrast, there were significiantly fewer violent assaults in the families of origin of Violence Syndrome Averters than in the family of battered women (Parker & Schumacher, 1977). This finding has tended to substantiate the postulate of vertical transmission of violence: women who did not observe violence in their family of origin found wife battering

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inconsistent with their role and were able to cope with and avoid further violence.

The observer does not have to be rewarded directly for aggressive behaviour to learn aggression as a problem solving strategy. Children who grew up in maritally violent homes could not help but see how their parents resolved conflicts using violence, withdrawal and compliance, and later imitated these methods when interacting with peers (Bellack & Antell, cited in Steinmetz, 1977, p. 29) and when resolving sibling conflict (Steinmetz, 1977).

Findings which supported the modeling of observed parents' behaviour patterns by children were provided by Hilberman & Munson (1978), who found that among the older children studied, difficulties arose along sex lines, with males being more aggressive and females more passive and withdrawn. Similarly, Sopp-Gilson (1980) observed children of abused women while they were at a transition house and found that within the first week the little boys in particular, began to mimic their male role-model and to exhibit a great deal of aggression; not only towards their mothers but also towards the staff and other children. In contrast, withdrawal and submission were common characteristics observed especially among the little girls.

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This latter group of children tried very hard not to be noticed and were generally quite far behind developmentally; in their speech, physical coordination; and social skills with their peers, as well as with adults (Sopp-Gilson, 1980).

Although these research findings have suggested an overall negative impact of family violence on children, Jaffe, Wolfe, Wilson, & Zak (1986) has noted that there is a great deal of variability, with individual children sometimes demonstrating few clinical symptoms. It appears that due to this variability, intervention programs for this population may have to be tailored to the individual child's current needs and circumstances.

2.5. REACTION OF CHILDREN TO STRESS

Sinclair (1985, pp. 88-90) has outlined the reactions that have been observed in children from violent homes and has separated them into groups according to age and stage of development. She has noted that any child could have these symptoms, but that children from violent homes are more vulnerable to excessive symptoms of stress.

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2.5.1. Preschoolers (birth to five)

This group of children were characterized as frequently suffering from physical complaints such as stomach-aches and headaches. They were also susceptible to sleep disturbances such as insomnia, heightened fear of the dark, and resistance to bedtime. Anxious symptoms such as bed-wetting and excessive separation anxieties were also noticeable in this young age group. Behaviours which exhibited separation anxiety included whining and clinging. Serious situations have resulted in a "failure to thrive" in young children.

2.5.2. School-age children (six to twelve)

This age group have often been observed becoming seductive or manipulative as a means of reducing tension in the home. Some of these children have stated the belief that by staying at home a lot, they can control the violence and will protect their mother. Other children have been noted for being the exact opposite. These children believe that by avoiding their home as much as possible, their absences will improve their parents' relationship. These children have been described by Sinclair as being very fearful. Fears exhibited by this age group include: fear of being abandoned; the fear of being killed or possessing the fear

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that they themselves might kill someone else; and fear of their own anger and others' anger. This age group has been noted for exhibiting eating disturbances such as overeating, undereating or hoarding food. Generally, school age children have been characterized by Sinclair as becoming insecure and disrespectful of their environment, especially if there are frequent unpredictable parental separations that the children are not informed about.

Sinclair has stated that the effects of sex-role socialization can be seen as children tended to separate their behaviours along sex lines. Girls have been noted for the continuation of somatic complaints, becoming withdrawn, passive, compliant, or engaging in clinging and approval-seeking behaviour. This has resulted in girls often becoming "mothers little helper". Boys on the other hand have been seen becoming more aggressive, engaging in acting-out behaviour, throwing temper tantrums, bullying and fighting with siblings and classmates. Both sexes have been described as suffering from impaired concentration spans, difficulty with school work, poor attendance patterns in school, fear of attending school and being labelled a slow learner or clumsy. On the other hand, some children have exhibited the opposite extreme. Some children display excellent academic work, set perfectionist standards for

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themselves, harbour a tremendous fear of failure, and become overly responsible, especially the oldest child.

2.5.3. Adolescence (thirteen and over)

All teenagers were described by Sinclair as being vulnerable to escapist, self-destructive behaviour. Adolescence was characterized as being a particularly stressful stage that becomes even more acute for those teenagers from a violent home. Teenagers from violent homes were shown as being vulnerable to the following extreme behaviours: escape into drug or alcohol abuse; running away from home; escape into pregnancy and early marriage; suicidal thoughts and actions; homicidal thoughts and actions and participating in criminal activities, such as drug-dealing and theft. Both Sinclair (1985) and Pressman (1984) have claimed that teenagers continue to differentiate their behaviour along traditional sex lines.

2.5.4. Young Women

Sinclair has stated that as the daughter of an abusive man enters puberty, the father may begin to treat her like a second wife. His jealousies and excessive use of control usually reserved for his wife, may now be directed towards

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his daughter. The father is characterized as being very suspicious of her interest in boys. His suspicious nature may be reflected in overt incestuous thoughts, if not actual incestuous behaviour (Walker, 1979). Often, the daughter has learned to hate her own body and feel confused about her sexuality (being female equals being like Mom equals being punished). Sinclair stated that the daughter may become sexually promiscuous or withdraw and completely deny her sexuality.

2.5.5. Young Men

A young man in a violent environment may try to become his mother's protector when his father is in the home. Ironically, if the father leaves the home, this same son often is seen as moving into his Dad's footsteps and starts to abuse his mother if he feels she is stepping "out of line". This was described by Sinclair as happening most often to the oldest child. If the oldest child is a daughter, Sinclair has postulated that the oldest daughter may adopt this role. The young man also may learn to hate his own body and feel confused about his sexuality (being male equals being like Dad equals being mean and abusive). He may be characterized as sexually promiscuous (sons are often encouraged by fathers to "sow their wild oats") or he

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might withdraw and completely avoid contact with the opposite sex.

2.6. SOCIAL LEARNING THEORY OF FAMILY VIOLENCE

Social learning theory has been one of the most common and empirically tested explanations for marital violence. It begins with the premise that the individual is a "tabula rosa, or clean slate" (Gelles and Straus, 1979, p. 562). A child learns that violence is an appropriate action through socialization within his family. He may learn this in one of three ways: 1) a child exposed to violence in his family incorporates this behaviour through imitation (Bandura, Ross & Ross, 1961; Rosenbaum and O'Leary, 1981); 2) a child exposed to or who has experienced violence within the family may learn norms that approve of violence (Owens and Straus, 1975); and 3) a child who views violence in an appropriate role model may learn to behave violently (Gelles and Straus, 1979).

Silver, Dublin & Lourie (1969) investigated 34 child abuse cases. The authors speculated that children learned violence as a coping mechanism. The child may cope with the emotional stress of abuse by having identified with and having imitated the aggressor, thereby developing poor

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impulse control. On the other hand the child may cope with abuse by having identified with the victim, equating love with being hurt and therefore imitating a pattern of harm to himself. As a result, abused children have grown up to be tomorrow's abusive parents and have the potential for being violent members of society. Silver et al. (1964) concluded that a learned pattern of violent behaviour was evident across three generations of abusive families, spanning twenty years.

Rosenbaum & O'Leary (1981) concluded in their research that the mere witnessing of spousal abuse can predispose the child to spousal violence in his own marital relationship. In addition, these children who have witnessed parental spouse abuse were more likely to have been abused by their parents.

Owens & Straus (1975) agreed that behaviour can exert a powerful influence upon attitudes, beliefs and cultural norms. If a child has observed others attaining their desired goals through the use of violent behaviour, his approval of violence will be greater. Steinmetz (1977) found a statistically significant relationship between the frequent use of a particular conflict resolution pattern for solving marital conflict and the frequent use of the same

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pattern for resolving parent/child and sibling/sibling conflict. These results have shown that physically aggressive parents were physically aggressive toward their children who in turn, learned to be physically aggressive toward siblings when solving conflict. It could be predicted that these children will solve their own marital conflict by utilizing physical aggression. By intervening with children from violent homes, we might be able to show these children that there are other appropriate means rather than physical aggression to cope with conflict. If the use of physical violence is a learned response, then it is also conceivable that it can be unlearned and replaced by more constructive coping mechanisms.

However, modeling of a behaviour alone was not considered enough to ensure that aggression was learned (Bandura, 1973). The model must have meaning to the child: that is, the closer the model resembled the child the more effective the modeling was. Therefore, the aggressive father was seen as having greater effect on his son than his daughter, and the daughter was more affected by the role the mother took in the incident. The parents were demonstrating problem solving techniques for their children.

The children were then encouraged to try out the

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behaviours. According to Davidson (1978) the boys were encouraged by their fathers to be good fighters, and loud mouths, and girls were encouraged to withdraw and become distrustful of men. Gregory (1976) reported that the girls from violent homes were often withdrawn and fearful and that the boys often reproduced aggressively the patterns of male behaviour they have experienced at home. MacLeod (1980) noted that there were often age differences. Younger children were frightened and protective of their mother. However, at around five or six, the children tended to lose respect for their mother, and some teenagers treated her suffering as part of the daily routine, and at times depersonalized her and blocked her from their consciousness and conscience. Dobash and Dobash (1979) wrote that children may have learned more from observing violence than simply to imitate it. They may have learned to accept, admire, emulate or expect such behaviour; but they may also have been repulsed by it and rejected its use.

In summary, children can be said to be damaged both physically and emotionally when there is wife abuse in the family. These children are taught certain beliefs about violence, and research has indicated that when children experienced violence either physically or emotionally; directly or indirectly, they become more tolerant of this

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form of behaviour and learned that it is acceptable to use aggression as a means of problem solving. If we are to break the cycle of violence, then we must re-educate the children who have come from violent homes, or they will grow up to become victims and perpetrators of interspousal abuse.

2.7. TREATMENT ISSUES FOR CHILDREN FROM VIOLENT HOMES

The children from violent homes were often not clear on consequences of their behaviour or their effect on others. At times, the children felt that the violence was their fault, particularly, if many of the arguments involved child rearing concerns. Many of the boys from violent homes used aggression as power in problem solving, while the girls were more likely to run from problems (Miller, 1982).

When the women and their children left the home and stayed in a shelter, the children have often not been informed of the reason for the move, which they have found very confusing, and which often involved changing schools and other disruptions. Alternately, the abused women may have abdicated all their responsibilities and turned to the children for the decision of whether or not to leave their husbands. This often gave the children the responsibility for losing their fathers and the women may even go so far as

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to return to their husbands if the children have not liked the shelter (Gordon & Sweeton, 1983).

Should the woman have decided to leave her husband permanently, the children were often elevated to meet her needs. Older children became surrogate parents to the younger children or the oldest son often became "the man of the house" (Gordon & Sweeton, 1983). This can be emotionally difficult for children who have not had a childhood.

Often the link between wife abuse and child abuse has been identified. The batterer may abuse both the wife and the children, or the abused wife may turn her frustrations on the children, and abuse them. Research conducted at Cheswik Womens Aid Hostel by Dr. John Gayford (1976) indicated that in 54% of the cases the men assaulted the children as well as the wife and in 37% of the cases the women admitted they discharged their frustrations in violence towards the children. In Dobash and Dobash's (1979) sample, about 20% of the men did at one time or other hit or punch one of the children very hard, usually the eldest.

Pressman (1984, pp. 43-44) has identified several issues

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for professionals working with children from violent homes. Pressman addressed the following developmental and situation specific areas:

- learning norms of behaviour regarding violence
- dealing with ambivalence about the abuser
- loss and mourning when mother separates from father
- dealing with the denegrating words of father regarding mother when children have visits with him
- helping mother be open with children regarding her decision to leave and reasons for leaving
- role-modeling of male-female relationships
- appropriate expression of feelings rather than withdrawal and aggression
- individuation when children are fused with mother
- support networks for stability (school, Big Brothers, YMCA Program)
- appropriate child role as opposed to parentified child and support for mother
- self-esteem
- trust.

In addition, Garwood (1985, pp. 1-2) also added the following treatment issues for one's consideration:

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- help the child come to terms with the problems occurring within his family
- impress on the child the importance of "not getting in the middle" or running interference in his parents dispute. In other words, supply the child with safety skills
- provide an opportunity for the child to recognize that he is not alone in his situation
- teach the child alternate, non-violent problem solving techniques, with the goal being prevention, in an effort to break the cycle.

Garwood (1985) noted that group treatment for children from violent homes was the preferred treatment modality. Pressman (1984, p. 123) agreed, stating that

> "although this (group therapy) is a relatively new modality for treating abused and neglected children, it is especially appropriate for latency-aged children who have interactional problems with their peers; furthermore, it has many of the same advantages noted in group therapy for adults".

Pressman (1984) has also agreed that for children, offering the presence of male and female co-therapists was particularly important for providing new parental models.

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2.8. CONCEPTUALIZATIONS ABOUT GROUP TREATMENT FOR CHILDREN

Group work with children has occupied the practitioner since the mid 1800s. Children were brought together in the spirit of reform. The group worker of this period focused early on children to rescue them from the throes of a materialistic environment and to help them grow and develop socially through group association (Alissi, 1980).

During the 1940's Redl and Konopka led a movement toward using children's groups for treatment purposes. By the mid 1950's, following World War II, social group work with children had broadened in scope and setting to include natural groups, recreational, educational and socialization groups for children in public schools and clubs, as well as groups for special populations such as the mentally ill or retarded, in residential settings and institutions. The early reformist group worker struggled against the tide of Freudian theory, a political climate which feared activist activities, and the growing affiliation between many group practitioners and the more clinically oriented caseworkers (Kennedy, 1985).

As a result, group treatment for children developed under the aegis of medicine and psychoanalytic theory.

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These origins were reflected in models of group therapy for children which historically have been directed towards differing aspects of ego functioning (Schamess, 1976). Similarly groups utilizing this model were largely described in terms of individual ego functioning. The most familiar traditional group modalities for the latency age child were the "activity group" (Slavson, 1943), the "therapeutic play group" (Schiffer, 1969), and the "non-directive play group" (Axline, 1947; Ginott, 1961). Schamess (1976) described the developmental group process common to these modalities according to three stages:

- permissive atmosphere
- regresses to his level of fixation and plays out the unacceptable impulses and conflictual feelings which have interfered with his development
- begins to develop either insight, better control over impulses, new identifications, or new sublimations that allow him to reintegrate at a higher maturational level. (p. 400)

The vernacular of this description was firmly rooted in the psychoanalytic language from psychotherapy with individuals.

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The behavioural science foundation for group work remained loose, and group work knowledge was charged with being based more on folklore than fact. As late as 1970 Whittaker bemoaned the parochial nature of group work, writing:

> If intuition becomes the only basis for practice, then doesn't practice itself become so idiosyncratic as to preclude even speaking of any group work method. (Whittaker, 1970, p. 319).

Also, Bernstein (1976) claimed that the developmental stages through which groups of children in social work treatment populations evolved were hypothesized according to practice experience, rather than theory, and awaited empirical support.

However, by the mid 1970's the practice wisdom of the group work field had come to enjoy the status of theory (Kennedy, 1985). It is now universally held that client groups pass through a series of stages and that social work interventions with groups can be guided by the particular issues raised at the various stages of group life.

The social worker has shared with the social psychologist a concern for the phases of group life and

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the characteristics of each given stage. Schutz (1958) summarized group movement as progressing through stages of inclusion, control, and finally, affection. Bion (1961) described three phases of firstly "flight", secondly "fight" and a third stage "unite". Bales and Strodbeck (1951) have proposed and tested a three phase model. These authors conceived of the early phase of group in which members collected information, a second middle phase, where members evaluated what they have found, and a final phase, where decisions were made and members became more supportive of one another.

The developmental phases of small groups have been observed and described by several social work writers (Sarri and Galinsky, 1964; Garland, Jones and Kolodny, 1965). These authors emphasized that the phases of group process were cumulative; the accomplishment of one phase, facilitating movement toward the next. Social work interventions in groups can be linked to facilitating the accomplishment of phases. The two major models of social group work, the "remedial" (Vinter, 1967) and the "reciprocal" model (Schwartz, 1961, pp. 7-34) have both been, despite significant differences, profoundly attentive to group processes.

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Present demands for cost and time efficiency, accountability and the need to cater to a variety of children's problems have begun to dictate the parameters of social work groups. Smith, Walsh and Gavin (1983) observed that children's groups have become time limited and that "traditional analytic groups have moved toward increased structure, and that social learning groups employ fantasy material" (p. 4). Borsky and Mozenter (1976) have advocated creative drama as an economical and broadly applicable vehicle for latency age therapy groups. Egan (1976) proposed that therapy which takes advantage of all modalities can bring about change faster than any one traditional approach to children's groups.

At present no definitive group model for working with children from violent homes has been described in the literature. This research will add to the existing body of knowledge by investigating a group work model developed to help children who have been exposed to family violence.

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2.9. SUMMARY

This chapter has presented the findings of scholarly writers, journal publications and other documents which help to provide a better understanding of how interspousal violence impacts on children who are raised in violent homes. In addition, information has been provided about group social work practice with children which suggests that utilizing a developmental group work model can be an effective means of intervening with children from violent homes. This chapter has included sections on the developmental tasks faced by children aged seven through to thirteen; the extent of the problem of family violence; the impact of family violence on children; treatment issues presented by this population; group social work with children, as well as theoretical constructs which suggest that family violence is learned within the family of origin and that without appropriate intervention, it is likely that family violence will be transmitted from one generation to the next.

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Chapter 3

RESEARCH DESIGN AND METHODOLOGY

This chapter presents the methodology utilized in this research. There are sections devoted to the historical beginning of the Chatham Demonstration Project, the population being studied, the statement of the primary hypothesis and sub-hypotheses being tested for statistical significance, and finally, the operational definitions which guided this research. Information is also provided about the experimental design chosen for this research, as well as the instruments chosen to do pre and post-group interviews, and the statistical analysis utilized in this research project. A section on the group social work model utilized in the research and content of group sessions are addressed. Finally, the limitations of the study are presented.

3.1. THE CHATHAM DEMONSTRATION PROJECT

This demonstration project was part of a larger study being conducted under the direction of Dr. Peter Jaffe of The London Family Court Clinic and Dr. David Wolfe,

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professor of psychology at the University of Western Ontario. These researchers have received funding from the Ministry of Community and Social Services to develop a group intervention model for the treatment of children who have witnessed parental violence. Under these researchers, treatment for the children from violent homes was undertaken in Guelph, Cambridge, Woodstock, London and Chatham in the fall of 1985.

Meetings of the researchers involved in this project started in March of 1985. Dr. Jaffe, his research team and this writer met regularly during the spring and summer months as they explored questions related to clarifying methodology that would be used, developed pre-test and post-test instruments and determined content issues for the groups.

The project began with a pilot group project in August of 1985 in Guelph. Two groups, one aged eight to ten and the other aged eleven to thirteen were run for children from homes where violence was experienced. The group met two hours per week for a total of ten sessions. Referrals came from the Family Counselling Service of Guelph and Marianne's Place, an abused women's shelter.

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Both group therapists were experienced in dealing with child witnesses to wife battering (a male therapist who was a second-year M.S.W. student on placement with a family therapy center, and a female co-leader who was a child care worker in a shelter for battered women). The therapists approached each session with general objectives relating to issues dealing with family violence and stimulated the children to express their feelings and share their experiences with one another. At each session, children were encouraged to discuss their attitudes about the topic in question (e.g., dealing with feelings of responsibility for the violence), and to seek alternative perspectives on viewing this issue through mutual discussion and problem solving. Specific examples were employed in order to facilitate the younger children's comprehension of the topic and its alternative solutions.

The group therapists (Andal, 1986) evaluated the initial impact of this early intervention group for children by interviewing the children and their mothers separately. The mothers felt quite positive about their children's attendance at the group sessions. The majority of the mothers perceived that their children enjoyed the group (93%) and that they learned something from their attendance (62%). Although only one-third of the mothers felt that the

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group had led to any significant behaviour change in their child, this was not surprising given the purpose of the group (attitude change and skill enhancement) and the gradual behaviour change that would be expected to result from the approach over time.

A brief discussion of the children's responses to the structured interview before and after the intervention sheds some light on the areas where they initially had a weaker understanding, as well as the utility of this group approach for affecting change. Regarding practical skills, more children could identify appropriate strategies for handling emergency situations (such as calling 911 or contacting a neighbour or relative) than before the group sessions (73% at post-test versus 44% at pre-test could identify three or more appropriate reactions to emergency situations). In terms of individual attitude change and self-perceptions, 85% of the children could identify two or more positive things about themselves (compared to 53% at pre-test). Most notably, group counselling was associated with a decrease in the extent of violence that the child condones in his/her family. That was to say, before the counselling, a sizeable proportion of children (25%) felt that it was appropriate for a man to strike a woman if the house was messy, for a woman to hit a man if he drank alcohol (55%), or for parents

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to hit their children if they do not do as they are told (95%). Following the program, very few of the children condoned marital violence (none of the children condoned a man hitting a woman, yet 14% condoned violence if the man stayed out late and was drinking). Not surprisingly, over half (53%) of the respondents still condoned corporal punishment by their parents for general rule breaking and non-compliance.

It was also interesting to note that the children did not want the group to disband when it came time to terminate. Some sessions were videotaped for training purposes and these tapes have been made available to group leaders running the subsequent groups.

Starting September, 1985, meetings were held between the research team and the executive directors of the Chatham-Kent Women's Centre and the Lester B. Pearson Centre For Children & Youth. Both executive directors agreed to the need for treatment services for these children and agreed to co-operate in getting this demonstration project off the ground. Both directors agreed to donate the services of one staff member to help with the running of the groups. Both directors also agreed to provide referrals and offered a space in which to hold client interviews.

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In order to evaluate the effectiveness of this treatment model, children participating in the group were given both a pre-group and post-group evaluation. However, some changes have been made in the way these services would be delivered in Chatham. It was agreed that a demonstration project be run in Chatham, complete with treatment and comparison groups. The design utilized in the other communities did not include a comparison group.

Letters were sent to agencies in Kent County that deal with violent families, asking for their co-operation in making referrals to the children's groups. The following agencies agreed to refer children for the program:

Chatham-Kent Women's Centre
Children's Aid Society of The County of Kent
Chatham-Kent Community & Family Services
Kent County Task Force on Family Violence
Lester B. Pearson Centre for Children & Youth

It was decided by this researcher that assignment to the treatment group would be on a "first-come, first-serve" basis due to the immediate need for treatment which the children exhibited. Indeed, professionals from whom

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referrals were being received, were all indicating that there was an "urgency" for treatment to begin.

Children were assigned to either the seven to ten or eleven to thirteen group according to their age. A comparison waiting list was established once the assignment to the treatment group was completed. Both the treatment and comparison groups had the pre-group and post-group instruments administered.

The treatment groups began on October 19, 1985 and ran once a week for one and one-half hours for a total of 10 sessions. Beginning in the latter part of January 1986, the comparison group was also offered group treatment, once a week for one and one-half hours, for a total of 10 sessions. This researcher believed it would be professionally unethical to collect personal data from the children and their parents and then not offer them the opportunity to take part in the treatment program. Also, agencies presenting referrals to this project had indicated that treatment would be beneficial for all the children referred.

The treatment groups started in October were the focus of this research. The groups were run by male and female co-leader. A social worker from Victoria Hospital in London

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took prime responsibility for leading the groups. This social worker had acquired several years of experience as a children's group worker. He co-led with a female staff member of the Lester B. Pearson Centre for Children & Youth for the seven to ten age group and co-led with a female staff member of the Chatham-Kent Women's Centre for the eleven to thirteen age group. Both female co-leaders had considerable experience working with children's groups.

The group leaders followed an agenda which suggested content issues to be used during the duration of the group sessions. Each session also included an activity component to help the children's interest. The group leaders also utilized a group work model which had become known as the "Boston Model of Group Work" (Garland, Jones & Kolodny, 1965).

With the exception of three sessions, all sessions were videotaped. Failure of videotape equipment accounted for sessions which were not videotaped. Videotaping was utilized for future training of staff purposes by the London Court Family Clinic, Lester B. Pearson Centre for Children & Youth and Chatham-Kent Women's Centre.

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3.2. POPULATION

Subjects in the present study were 28 children who had been exposed to marital violence in their homes. The referral source was able to verify that there had been at least one violent incident in the child's family life within the past year. Further, criteria for determining the child's exposure to family violence was based upon report of the mother. Evidence of frequency and intensity of violence occurring in the family within the past year was determined by independent ratings of responses to items in the physical aggression sub-scale of the Conflict Tactics Scale administered to the mother. While the extent of child abuse was measured as well, it was not used to exclude children from the study. The only children to be excluded were those who in the opinion of the referring agency and this researcher would not benefit from the group experience due to intellectual deficiency or inability to function in a group setting.

There were a total of 33 referrals received from referring agencies. Consultations with counsellors who made the referrals resulted in rejecting one child for reasons of intellectual deficiency and two children were rejected on grounds that group treatment would not be an appropriate

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treatment modality for these children at the present time. The parents of two children did not allow their children to participate in the study.

The first fourteen referrals accepted were assigned to one of the two treatment groups, either the seven to ten age group, or the eleven to thirteen age group, according to the child's age. The remaining referrals were assigned to one of two comparison waiting lists; the waiting list for either the seven to ten age group or the eleven to thirteen age group, again the child being differentiated according to age.

Two children assigned to the treatment groups moved out of the area during the week prior to the start of the group and thus were not available for this study. The custodial parents of one child assigned to the younger treatment group found that the dates of the treatment group were inconvenient for their family and thus this child was re-assigned to the comparison waiting list for the younger group. This resulted in a total of 11 children participating in one of the two treatment groups which began in October of 1985 and ended prior to Christmas.

Seventeen children were placed on one of the two

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comparison waiting lists. These children were offered group treatment services starting in January, 1986. The same pre-group and post-group evaluation instruments were administered to both treatment groups and both comparison waiting lists prior to the start of the group intervention and following the end of the group intervention.

The final result was that five children participated in the seven to ten age treatment group and six children participated in the eleven to thirteen age treatment group. Seven children were assigned to comparison waiting list for children aged seven to ten and ten children were assigned to comparison waiting list for children aged eleven to thirteen. As noted previously, assignment to either treatment group or comparison waiting list was non-random, carried out in order of receipt of the referrals.

The population utilized in this research was then defined as being "children from Kent County between the ages of seven to thirteen who have been exposed to family violence and who have been referred for social work group treatment by agencies which deal with violent families".

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3.3. HYPOTHESIS

It was hypothesized that children who have been exposed to family violence will show improvements in cognitive and behavioural skills following treatment, compared to no treatment comparisons. In addition, a broad measure of child adjustment and mother's report will reflect improvements in child conduct.

In addition, several sub-hypotheses were also tested. Each hypothesis was accepted or rejected at the .05 level of probability using a one-tailed test. The alternative hypothesis H_i: $u1-u2>0$ was tested against the null hypothesis H_o: $u1-u2\leq 0$.

The following were the sub-hypotheses tested:

1. It was hypothesized that there will be a significant reduction in the level of fear experienced by latency aged children in the treatment group, compared to no treatment comparisons, following treatment.

2. It was hypothesized that there will be a significant reduction in the level of fear

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experienced by early adolescent children in the treatment group, compared to no treatment comparisons, following treatment.

3. It was hypothesized that there will be a significant reduction in latency aged children's negative perception of stressful life events, compared to no treatment comparisons, following treatment.

4. It was hypothesized that there will be a significant reduction in early adolescent children's negative perception of stressful life events, compared to no treatment comparisons, following treatment.

5. It was hypothesized that there will be a significant improvement in the latency aged children's perception of sexual roles, compared to no treatment comparisons, following treatment.

6. It was hypothesized that there will be a significant improvement in the early adolescent children's perception of sexual roles, compared to no treatment comparisons, following treatment.

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7. It was hypothesized that there will be a significant difference in the latency aged children's ability to utilize social supports when the children have a problem, compared to no treatment comparisons, following treatment.

8. It was hypothesized that there will be a significant difference in the early adolescent children's ability to utilize social supports when the children have a problem, compared to no treatment comparisons, following treatment.

3.4. DEFINITION OF CONCEPTS

Latency Aged Children: Latency aged children were defined as male and female children between the ages of seven and ten.

Early Adolescent Children: Early adolescent children were defined as male and female children between the ages of eleven and thirteen.

Latency and Early Adolescent Treatment Groups: Latency and early adolescent treatment groups referred to the

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developmental group model utilized by the two treatment groups in this research study.

No Treatment Comparison Group: No treatment comparison group referred to the latency and early adolescent children who were assigned to the comparison waiting list for either seven to ten year olds, or eleven to thirteen year olds, according to their age. When the phrase no treatment comparison group appeared in a hypothesis statement, it was assumed that this researcher was referring to children on the comparison waiting list corresponding to either latency aged or early adolescent treatment groups referred to in the hypothesis statement.

Yo-Yo Children: A term coined by J. G. Moore used to describe children from violent homes. Moore felt that children from violent homes were frequently uprooted from their homes, when their mothers sought refuge from their battering spouses. However, these mothers frequently returned to their spouses. Thus, their children might be "bounced around" from one home to another, just like a yo-yo.

All Children: Some of the research results that have been illustrated and discussed in this study were the

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aggregate data collected from both age groups. However, the term "all children" has appeared in this research. All children was defined as the sum of all children in both latency aged and early adolescent groups.

Young Children: Young children referred to the latency aged children between the ages of seven to ten.

Old Children: Old children referred to the early adolescent children between the ages of eleven to thirteen.

All Treatment: All treatment referred to all children between the ages of seven to thirteen who received treatment.

Young Treatment: Young treatment referred to the latency aged children between the ages of seven to ten who received treatment.

Old Treatment: Old treatment referred to the early adolescent children between the ages of eleven to thirteen who received treatment.

All Comparison: All comparison referred to all children between the ages of seven to thirteen who were assigned to

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the comparison waiting list.

Young Comparison: Young comparison referred to the latency aged children between the ages of seven to ten who were assigned to the comparison waiting list.

Old Comparison: Old comparison referred to the early adolescent children between the ages of eleven to thirteen who were assigned to the comparison waiting list.

Broad Measure of Child Adjustment: Broad measure of child adjustment refers to the Parent's Child Behaviour Checklist developed by Thomas M. Achenbach and Craig Edelbrock. The Parent's Child Behaviour Checklist is a standardized instrument which was utilized to measure the overall level of the children's behavioural problems.

Social Supports: Social supports were defined as being persons within the family of origin, extended family, or the community at large who the child approaches to get help with a problem.

Violence: There are many defnitions for the word violence, depending on the perspective one prefers. One may define violence from a psychological, physiological,

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sociological, or cultural perspective. In this research, violence was defined as being any one of, or a combination of ways used to express violent activities identified by the aggression sub-scales of the Conflict Tactics Scale.

Cognitive Abilities: Cognitive abilities was defined as the child's ability to engage in problem solving skills.

Problem Solving: Problem solving was defined as the child's ability to generate alternative solutions to personal and family problems and to comprehend consequences and strategies for coping with difficult interpersonal situations.

Improvement in Adaptive Thinking Process: Improvement in adaptive thinking process was defined as improvements in both cognitive and behavioural skills.

An improvement in Behavioural Skills: An improvement in behavioural skills was defined as a noticeable improvement in behaviour as reported by the childrens' mothers.

Child Questionnaire: The child questionnaire referred to the instrument given to each child in both treatment and comparison waiting list groups prior to start of treatment

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and following the end of treatment. This questionnaire included all the measures or tests used to determine the outcome of the demonstration project. These included:

a) the fear survey,
social supports scale,
life events checklist, and

b) criteria which collect data on safety skills,
responsibility for violence,
responsibility for parents,
wishes and attitudes toward the absent parent,
sexual stereotyping,
child's attitude and response to anger, and
child's self concept.

3.5. RESEARCH DESIGN

A quasi-experimental, non-equivalent comparison group was utilized in this research pboject.

(1) O_1 x O_2 (Treatment group)

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(2) O_1 O_2 (Comparison group)

(Grinnell, 1981, p. 221)

where O_1 = pre-testing of treatment and comparison groups

O_2 = post-testing of treatment and comparison groups

x = intervention of treatment group

The purpose for conducting this research project using a quasi-experimental design was to ensure some degree of external validity. This refers to the ability to generalize the results from this study to other similar populations (Tripoldi, Fellin, & Meyer, 1969, p. 28).

Through the use of treatment and comparison groups, this was accomplished. Children in the comparison groups had also witnessed family violence. The children in the comparison groups were not involved in their own groups until all treatment groups for children ages seven to ten and children ages eleven to thirteen were completed.

Grinnell (1981, p. 221) has stated that the greatest weakness of this design was that experimental mortality cannot be adequately controlled. No measures could be utilized to control for selection biases since assignment to group was in the order in which referrals were received.

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However, it is interesting to note that there were no drop-outs in either treatment or comparison groups during the course of the intervention, so that differential mortality was not an issue. This design did control for effects of maturation, testing, instrumentation, practitioner bias, effects of history, but statistical regression was not controlled. Since the entire population was utilized, it appeared safe to say that the subjects were representative of the population being studied.

3.6. ADMINISTRATION OF PRE-GROUP INSTRUMENTS

Pre-group interviews with mother and child were held at the Chatham-Kent Women's Centre in Chatham. These interviews were conducted by this researcher. With both mother and child present, the purposes of the group were reviewed, as well as how participation in the group might benefit her child. The child's feelings about participation in groups were explored. The fact that sessions would be videotaped and that research data would be collected for publication by Dr. Jaffe and by this researcher was explained. A commitment by parent and child to have the child take part in the group was then obtained.

The mother and child were interviewed separately. The

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instruments noted above were administered. After both interviews were completed, mother and child were brought back together. After receiving a final commitment from the parent and child allowing the child to attend the group, necessary consent forms were signed by both parent and child.

3.7. ADMINISTRATION OF POST-GROUP INSTRUMENTS

The mother and child were both interviewed together, before the administration of the post-group instrument. A general progress report was provided on how the child fared in the group as seen through the eyes of the group leaders.

The child and the mother were then interviewed separately and the post-group instruments administered. The post-group instruments included an evaluation sheet which was administered to both the mother and child. After this was completed, the child and parent were brought back together again. Recommendations that group leaders suggested for further clinical interventions were shared if this was deemed appropriate. If further intervention was suggested, help with referral was offered. Further reactions to the party's participation in the project were solicited and closure was given to the process.

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3.8. DETAILED DESCRIPTION OF INSTRUMENTS UTILIZED IN RESEARCH PROJECT

3.8.1. Mother

In the pre-group situation, children's behaviour was measured using the Achenbach Child Behaviour Checklist (CBCL, Achenbach & Edelbrock, 1983). The checklist was a parent rating of the child's social competence and behaviour problems as judged by the parent over the past six months. Thus, the instrument would normally be administered once every six months. However, in our study, there was a mean time of four months between administration of the pre and post-test instruments. It should be recognized that this may have an effect on the reliability of the results obtained by using this measure. The CBCL measure was utilized to determine the child's sum total behaviour problems as well as being one of the instruments utilized in testing for statistical significance of the primary hypothesis.

A total behaviour problem score (Sum T) was used to provide a summary estimate of the child's level of adjustment. This factor was selected because of its overall behavioural qualities and because of its psychometric

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properties. Achenbach & Edelbrock (1983) report test-retest reliabilities for this score ranging from .89 to .97 across the ages and sexes used in this study. Construct validity was established by constructing the CBCL with the Commers (1973) Parent Questionnaire and the Quay-Petersen Revised Behaviour Problem Checklist (cited in Achenbach & Edelbrock, 1983, p.5). Correslations with the Sum T range from .77 to .91 with the Commers and .71 to .92 with the Quay-Petersen.

Three aggression sub-scales of the Conflict Tactics Scale (Straus, 1979) were administered to the mother to measure the amount of physical violence between spouses. Conflict resolution strategies were rated by the mother on a seven point scale according to the frequency of their occurrence over the past 12 months (0=never and 6=more than 20 responses to 18 items comparing the three aggression sub-scales which included reasoning, verbal aggression, and violent aggression). The instrument was scored by simply totaling the number of responses on the seven part scale for each sub-scale and then totalling the sum scores of the three sub-scales (Straus, 1979). Ratings can be obtained for wife to husband and husband to wife violence. This instrument then provided a continuous measure of the child's exposure to physical violence in the home.

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The physical aggression sub-scale was also utilized to measure aggression toward the child. The mother was asked to rate nine items corresponding to their frequency of use over the past 12 months. By totalling the ratings for each item, one can measure the aggression directed at the child by father to child and mother to child.

The CTS scale was found to be a reliable and valid measure of parent child and adult to adult aggression in a large representative sample of families (Straus, 1979; Straus, Gelles, Steinmetz, 1980). Straus (1979) has provided adequate internal reliability for adult-to-adult violence (alpha=.82) and for parent-to-child violence (alpha=.62). He further established concurrent validity by comparing the child's reports of violence between parents with the parent's reports. The correlations between children reports and the husband and wife reports were .64 and .33 respectively. Straus (1979) also cited evidence of construct validity based on research that had found relationships between the CTS scores and in-depth interview studies, intergenerational transmission of violence, and other variables. However, due to the nature of the questions asked on the CTS, the measure has produced low to moderate levels of test-retest reliability. These lower levels of reliability may have an impact on the

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interpretation of the reporting of adult to child violence. Parents may be hesitant to report this type of violence due to social and legal ramifications. Due to the potentially negative consequences of reporting physical violence directed to children, Straus (1979) predicted that any violence that is reported will likely be an underestimate of the actual violence that occurred.

In addition to the Child Behaviour Checklist and Conflict Tactics Scale, the mother completed a face sheet which was used to collect demographic data about the family. In the post-group situation, the mother was asked to complete another face sheet collecting demographic data, and an evaluation form in which she was asked about behavioural changes noted in the child and how much she felt that child enjoyed and learned from the group experience. The instruments were administered to mother in the pre and post-group situations with both the treatment and comparison waiting list groups.

3.8.2. Child

The child behaviour questionnaire was administered to the child in both the pre and post-group situations. There were series of standardized tests included in the child

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questionnaire. All children in the treatment groups and comparison waiting lists were given the child questionnaire.

Child's perception of positive and negative parental behaviour were assessed using a modified version of the Parent Perception Inventory (Hazzard, Christensen, & Margolin, 1981). In the original scale, the child is asked to rate nine positive and nine negative parental behaviour classes (e.g. "How often does your mom say nice things to you, compliment you, praise you?") on a five point scale (never, a little, sometimes, pretty much, a lot). The scale is completed separately in reference to mother and to father. Responses are divided into four sub-scales - mother positive, mother negative, father positive, and father negative, each with a potential score ranging from 0 to 36.

Due to the youthful age of some of the children (as young as seven years), it was felt that a five point scale was rather confusing to so young a child. Therefore, a three point scale - never, sometimes, often was used. The items remain the same as do the four sub-scales, as were references to mother and father. The instrument was scored on the basis of never=0, sometimes=1, and often=2. Scores can be derived from each sub-scale by totalling the scores in each of the sub-scales, and an overall score by totalling

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the scores of the sub-scales.

Since the original scale has been modified, no normative data were available, although the original scale was considered to be a valid and reliable instrument (Hazzard, Christensen, & Margolin, 1981).

3.8.3. Life Events

The child's stress related to life events was measured by an adapted version of Johnson and McCutcheon's Life Events Check List (1980). This measure was used to control for frequency and intensity of life events perceived by the child. The child was asked to indicate those events that have occurred in the child's life during the previous year, to note whether the event was good or bad for them, and to indicate the impact on effect that the event had on their lives. From the checklist, a negative life change score was derived by summing the impact ratings of those events rated as negative. Once a child has identified that the item had a bad effect on him, a score was derived from the impact where a lot=2, a little=1, and no effect=0. Since this research utilized an adapted scale, no normative data was available. A simplified form of the original scale was utilized to take into consideration the children's level of

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cognitive development.

3.8.4. Child's Social Support

A very much shortened and simplified form of Procidano and Heller's (1983) Social Support Scale was utilized in this research. The child was asked to identify on a nine item scale, how often he sought out others to help him with a problem. The child may have sought help from someone within his own family or someone outside the family. The child was asked to note this on a three point scale, whether the child went to a significant other never, sometimes, or often. The scale was scored by summing the scores received on this nine item scale. A zero score was assigned if the child never went to a specific person, 1=sometimes, and 2=often. No normative data was available since this was a modified scale.

3.8.5. Fear Survey

A modified fear survey to measure the level of fear experienced by the child at a time of testing was also utilized in this study. The original scale had been developed by David Wolfe from the University of Western Ontario (Wolfe, unpublished manuscript). This study

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utilized a shortened version of Dr. Wolfe's scale. Normative data on Dr. Wolfe's scale has not yet been published. The scale utilized in this study consisted of 45 items ranked on a three point scale. The child identified if he had a specific fear none of the time, some of the time, or a lot of the time. A score of none of the time=0, some of the time=1, and a lot of the time=2 was assigned to each item. The sum of all these indicated the total level of fear.

3.8.6. Other Issues in the Child Questionnaire

Pressman (1984), Sinclair (1985) and Garwood (1985) in their writings, all identified treatment issues that need to be addressed in designing an intervention strategy for children from violent homes. Using the available literature as a guide, the child questionnaire also addressed other criteria which impacted on children from violent homes. These were identified as follows: safety skills, responsibility for violence, responsibility for parents, wishes regarding the absent parent, attitudes and responses to anger, sexual stereotyping, and self concept.

In developing the child questionnaire, the child's attitudes and responses to all these areas were explored.

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For example, the child was asked what he did if he saw his father hitting his mother. The child was asked to respond to a number of specific choices. Fixed alternative questions were developed since it was believed that children would find it more difficult to respond to open-ended questions. Also, close-ended questions are easier to score. Since the topic matter was very sensitive, the close-ended questions were expected to elicit more data than would otherwise be obtained. The child was asked to respond to each alternative, indicating if he reacted by using this alternative or not. In this way, a specific response was examined statistically as well as a series of alternatives. The child responded with a "yes" if the alternative applied to him, and a "no" if it did not. Each alternative was scored as being an appropriate or inappropriate response. Granted, there was a weakness, and that was that there were no normative data with which to compare and contrast the responses of these children. However, the children's responses were examined by isolating a specific alternative variable, or combination of alternatives and/or variables. For scoring purposes, an appropriate response=0, and an inappropriate response=1. Simply by summing up the score on different alternatives by variable provided one with the opportunity to do a statistical analysis of data collected.

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Finally, the child who had received treatment was asked to complete an evaluation in which information on how much he enjoyed the group, what he had learned from the group, and what he did not like about the group was solicited. These questions also helped in discussing how the child felt about leaving the group and helped the child to bring closure to the entire process.

3.9. ANALYSIS OF THE DATA

Descriptive statistical techniques measuring frequency distributions and measures of central tendencies were utilized to examine selected variables to determine if there were any characteristic responses being obtained from children who have been exposed to violence in their homes. In the post-group situation, selected variables were examined through the use of frequency distribution percentages to determine if there were any characteristic responses emerging for children who have been exposed to violence in their families after these children have received treatment.

Descriptive findings discovered during the analysis of the post-group data were reported only if the reporting of this information added new information to the profile of

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characteristic responses of the children from violent homes generated by the pre-group interview, or if a different pattern of responses was generated by those children who had been exposed to treatment. If there was no statistically significant difference between the information collected between the pre and post-group data, the data was not included in the discussion of the study's findings.

Inferential statistics were utilized to test for significance between all selected variables. In situations where nominal scores from the pre-group or post-group interviews were being examined, the chi-square test adjusted for continuity was used. Also, the alternative hypothesis Hi: $u1-u2>0$ was tested against the null hypothesis Ho: $u1-u2\leq 0$ in situations where predicted relationships between independent and dependent variables were believed to exist. Each hypothesis was accepted or rejected at the .05 level of probability using a one-tailed test. Significance was considered in the positive direction only. Paired comparison t-tests were utilized to test for, a) the main effect for groups, b) the main effect of occasion, and c) the main effect for interaction. Grinnell (1981, p. 518) has written that utilizing one-tailed test of significance is appropriate when utilizing a nonequivalent comparison group design.

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Grinnell (1981, p. 523) has also written that the "test of interaction asks whether two groups change at the same rate, or one group changes more than the other". Grinnell (1981, p. 523) stated that the main effect for interaction tests whether the mean change for one group (the treatment group) was different than the mean change for the other group (the comparison group). Testing for the main effect of interaction was achieved by computing a simple Anova of Change Scores. The results of the Anova of Change Scores was reported in this study, since the focus of the research findings was to determine whether treatment could produce the predicted changes stated in the alternative hypothesis. If t-tests only had been utilized in this study, statistical significance for the variables tested could have been reported, however, information as to the causes of the statistically significant finding would be lacking; whether significance was accounted for by the main effect of groups, occasions or interaction. Results for main effect for groups or main effect for occasions was reported only when these tests produced statistically significant results or when reporting these results was beneficial in understanding and providing possible explanations for results that were obtained.

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A chi-square test adjusted for continuity was utilized if the variable appeared only once, either in the pre-group or post-group instrument, and paired comparison t-tests were utilized if the variable appeared in both the pre-group and post-group instrument. This was considered necessary since a non-random experimental design was used in this research. It was felt important to be able to identify if the impact of the intervening variables was the same or different for the treatment and control groups studied in this research. Attempts were made to control for possible intervening variables that were within the control of this researcher. Intervening variables that were not within the control of this researcher were also cited in the discussion of the analysis of the data.

Appropriate tables were utilized to highlight and illustrate the results obtained from selected variables. In these tables, the results from the latency aged and early adolescent treatment and comparison groups were reported, as well as the results for the aggregate of all treatment and all comparison children. The rationale for this was that since the populations of both latency aged and early adolescent children were small, the results obtained may have been subject to size-effect error. In order to control for the possible impact of size effect error, the aggregate

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results for all treatment and all comparison children were reported. It can be argued that reporting the aggregate data for the sum of both latency aged and early adolescent children was perfectly legitimate since both treatment groups received treatment using the same group work model and the content of group sessions was similar in both the themes that were presented and the new skills that were being explored and learned.

The groups described within the tables were not identified by utilizing the terms "latency aged" and "early adolescent" children. Rather the groups were identified as either "young children" (young treatment or young comparison) or "old children" (old treatment or old comparison). The rational for this was purely cosmetic. For convenience purposes in preparing the tables, it was much easier to use the term "young" and "old" to describe the different children's groups. Naturally, the term young children was defined as referring to the latency aged children and the term old children was defined as referring to the early adolescent children.

3.10. THE TREATMENT GROUPS

The topics that were dealt with in the weekly sessions

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were designated in an effort to address the most important issues faced by the children from violent homes. These themes allowed children to discuss feelings, mother and father, family violence, problem solving, separation and divorce, families, self esteem, safety skills and taking care of themselves. In acknowledging these areas as being relevant to their own situations, children learned that their problems are workable and that there are solutions to help them. A critical part of this process was teaching the children to appreciate themselves and their own abilities and this was stressed throughout the ten sessions. Appendix A provides the session by session guideline utilized by the group leaders to insure that the identified themes were covered.

The focus in the sessions with the children was upon learning an adaptive thinking process, in contrast to a behaviour emphasis on teaching specific skills or behaviours and the traditional dynamic emphasis on uncovering internal conflict and unconscious motivations. Strategies that aid a child to adapt in a variety of settings were encouraged and were processed in the group. In this way, it was believed the child's problem solving skills would be improved.

Specific techniques that were utilized to promote

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adaptive thinking varied between the two groups as techniques appropriate for the age groups were utilized.

Throughout this work with the children, the group leaders exhibited a concern for the phases of group life and the characteristics of a given stage of group life. In this way, both group leaders recognized that the phases of a group process were cumulative, the accomplishment of one phase, facilitating movement toward the next.

In termination of the groups, the children were given the opportunity to evaluate their progress, recognize their gains, and give each other verbal gifts as part of the process of saying good-bye. The pain of separating and closing relationships was also acknowledged and explored.

The developmental group work model chosen for this research has been known as the "Boston Model" (Garland, Jones, & Kolodny, 1965). The group phases and worker roles identified in this model are provided in Appendix B.

3.11. LIMITATIONS OF THIS STUDY

The small number of children prevented testing of some concepts that would be helpful to expanding the knowledge

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regarding children's reactions to being exposed to family violence.

The fact that children exposed to family violence were recruited from only a limited number of agency caseloads may limit generalization to other settings.

The participants were limited to only those children known by agency personnel to having been exposed to family violence.

The selection of participants was not based on random procedure.

The parents have to give signed approval for their children to be allowed to participate in the treatment or comparison groups.

3.12. SUMMARY

This chapter has presented the methodology utilized in this research. There were sections devoted to the historical beginnings and development of the Chatham Demonstration Project; the group model used and content of group sessions; the population; the primary hypothesis and

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sub-hypotheses; definition of concepts; research design; the administration of pre and post-group instruments; descriptive and statistical analysis of data; and this chapter concluded with the limitations of the study.

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Chapter 4

EVALUATION OF THE DEMONSTRATION PROJECT

This chapter reports the findings of the research project. Both descriptive findings as well as data tested for statistical significance are reported. Demographic data generated from the pre and post-group interviews with both the mothers and children who participated in this research are presented. This is followed by a discussion of the analysis of the data collected to test the primary hypothesis and the sub-hypothesis as outlined in the methodology chapter. Throughout this chapter, the results that have been reported are interpreted in light of what is already known about family violence and compared with the findings of other researchers who have studied the impact of family violence on children. There is also a discussion of the evaluation of the group experience as reported by both the children and mothers who were interviewed regarding the child's participation in the treatment groups.

4.1. MOTHERS' DESCRIPTION OF VIOLENCE WITHIN THE FAMILY AND ITS IMPACT ON THEIR CHILDREN

Rosenbaum and O'Leary (1981), Emery (1982) and others

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have provided evidence that children who are exposed to violence between their parents are more likely to show short and/or long term adjustment difficulties. Jaffe, Wolfe, Wilson and Zak (1985) have utilized the Achenbach Child Behaviour Checklist to measure the level of adjustment difficulties experienced by children from violent homes. They have found a significant prevalence of behaviour problems and diminished social competance in children from these homes.

The following table summarizes both the Total Behaviour mean scores and Social Competance mean scores obtained in this research.

Table 1

Mothers' Pre-test Report: Mean Scores for Achenbach Child Behaviour Checklist

Group	N	Total Behaviour T		Social Competancy T	
young treatment	5	$\bar{x}$=70.2	S.D.=6.1	$\bar{x}$=42.4	S.D.=10.7
old treatment	6	$\bar{x}$=73.8	S.D.=6.5	$\bar{x}$=34.0	S.D.= 4.9
all treatment	11	$\bar{x}$=72.2	S.D.=6.3	$\bar{x}$=37.8	S.D.= 8.8
young comparison	7	$\bar{x}$=69.1	S.D.=7.9	$\bar{x}$=39.0	S.D.= 8.5
old comparison	10	$\bar{x}$=69.5	S.D.=9.3	$\bar{x}$=35.2	S.D.= 9.3
all comparison	17	$\bar{x}$=69.4	S.D.=8.5	$\bar{x}$=35.1	S.D.= 8.7

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Achenbach and Edelbrock (1983, p. 68) have found that T scores above 70 on the total behaviour scale and T scores below 30 on the social competance scale represent approximately the 98th percentile, and the 2nd percentile respectively of normative samples. These authors have stated that an inverse relationship exists for clinical status between behaviour problem scores and social competency T scores. Therefore, Achenbach and Edelbrock have defined children obtaining total behaviour scores of greater than 70 and social competency scores of less than 30 as falling within the clinical range. According to Jaffe et al. (1985) children who have scored greater than 65 on the total behaviour T are considered as scoring high on behavioural problems, since only 7.5% of a normative sample obtain scores within this range. Similarly, children who have scored 35 or less on social competency can be considered as scoring low on social competency since only 7.5% of a normative sample would obtain scores within this range.

The data collected from the Achenbach revealed a mean total behaviour T score of 72.2 for all children in the treatment groups and a mean total behaviour T score of 69.4 for all children in the comparison groups during pre

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testing. Further, a mean social competency T score of 37.8 was obtained for all treatment children and a mean social competency T score of 35.1 was obtained for all comparison children during pre-testing. Thus this research has added further support to the findings of researchers who have agreed that children from violent homes tend to exhibit a high level of behavioural problems and a low level of social competancy. Indeed, it was because of the concern for the well-being of children from violent homes that a group program was developed to help respond to the behavioural and social needs of these children.

A substantial body of research has suggested that there is some relationship between the incidence of marital discord in the home and the existence of behaviour problems in children. Therefore, it can be argued that it is important to look at the impact of exposure to marital violence on children.

In this study, the mothers reported their exposure to various forms of marital violence in the past twelve months through their responses to the aggression sub-scales of the Conflict Tactics Scale. The violence scores for "male to female" (husband to wife) and for "female to male" (wife to husband) were of primal interest to this researcher. The

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total violence scores for each category were obtained by summing the response category code values for each item, but omitting responses under the "don't know" column. The maximum score possible was 60 (10 items, with a maximum possible score of 6 for each item).

Thus, the Conflict Tactic Scale (CTS) was used to assess the mother's perception regarding the frequency and severity of marital violence. However, it must be remembered that the mother's report may be biased by two factors. First, it can be considered very difficult to remember with any accuracy the exact frequency with which an event occurred over the span of an entire year. Secondly, because of the mother's personal involvement in a violent relationship, she may be less than objective in what she has reported. She may tend to over report the frequency of how often she was assaulted either physically or verbally, or she may be less than truthful in reporting the frequency and intensity of situations where she may have initiated forms of aggression against her male partner.

The following table summarizes the scores obtained from the mothers to the physical aggression sub-scale of the CTS.

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Table 2

Mothers' Report: Responses to Physical Aggression Sub-scale of the Conflict Tactics Scale (CTS)

Group	N	Female to Male		Male to Female	
young treatment	5	$\bar{x}$=6.6	S.D.=4.6	$\bar{x}$=13.4	S.D.=8.2
old treatment	6	$\bar{x}$=1.7	S.D.=2.6	$\bar{x}$= 9.0	S.D.=4.9
all treatment	11	$\bar{x}$=3.9	S.D.=4.3	$\bar{x}$=11.0	S.D.=6.6
young comparison	7	$\bar{x}$=4.3	S.D.=4.9	$\bar{x}$= 9.6	S.D.=8.3
old comparison	10	$\bar{x}$=4.6	S.D.=5.3	$\bar{x}$=10.1	S.D.=8.3
all comparison	17	$\bar{x}$=4.5	S.D.=5.0	$\bar{x}$= 9.9	S.D.=8.3

The violence scores were found to be higher for the "male to female" category than the "female to male" category, with the male partner scoring a mean value of 11.0 for all treatment families and a mean value of 9.9 for all comparison families. In the "female to male" category, a mean of 3.9 was obtained for all treatment families and a mean of 4.5 was obtained for all comparison families. An inspection of standard deviation obtained indicates a wide range of variance. Thus, it can be argued that there was a considerable variation in both frequency and intensity of violence present from one family to another. The variation obtained on this measure was expected. The criterion for participation in the group was that the child had witnessed

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at least one violent incident within the past year. Therefore, it was expected to have children participate in the study who came from families in which physical aggression was frequent as well as infrequent. The finding that "male to female" violence was considerably more frequent was consistent with previous research findings which have shown that battered women are at risk from their male partners.

In interpreting the scores received on the CTS, it is important to recognize that the range of scores possible for each item was small (1-6). Therefore, even numerically small changes may have importance. Also, it is important to give recognition to the fact that differences between coded values on any of the sub-scales of the CTS do not represent equivalent differences. A response coded with the value 1, indicates that the subject has been subjected only once in the past year to the specific form of aggression being inquired about. A coded value of 2 indicates that he/she has experienced two occasions of violence within the past year. A coded value of 3 means that there has been 3-5 occasions within the past year that he/she has been exposed to violence. A coded value of 4 means that there has been 6-10 occasions of violence within the past year. A coded value of 5 means that there has been 11-20 occasions of

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violence within the past year. A coded value of 6 means that there has been more than 20 occasions of violence within the past year.

The mothers reported that their children had been exposed to seeing their parents pushing, grabbing, shoving, hitting, kicking and beating each other, and on some occasions, this was with an object. An interesting result was that this research showed only a mean of 1.7 for physical aggression in the "female to male" category for the children in the early adolescent treatment group. A possible reason for this could be that the scores from one parent biased these results. This particular mother had all three of her children in the older treatment group. She reported that she had been physically aggressive with her former spouse only on rare occasions.

In addition to witnessing physical abuse between parents, the mothers also reported that their children had been exposed to verbal abuse. The children were exposed to parents insulting each other, sulking, stomping out of the room, crying, and doing something to spite each other. Verbal aggression was measured by the mother's response to the verbal aggression sub-scale of the CTS. The verbal aggression score was obtained in a similar manner to that of

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the physical aggression violence score, except that the maximum possible score was 30 (five items, with a maximum coded value of 6 for each item).

The following table indicates the results obtained.

Table 3

Mothers' Report: Responses to Verbal Aggression Sub-scale of the Conflict Tactics Scale (CTS)

Group	N	Female to Male		Male to Female	
young treatment	5	$\bar{x}$=17.4	S.D.=2.1	$\bar{x}$=18.0	S.D.=8.2
old treatment	6	$\bar{x}$=16.3	S.D.=2.9	$\bar{x}$=22.2	S.D.=9.5
all treatment	11	$\bar{x}$=16.8	S.D.=2.5	$\bar{x}$=20.2	S.D.=8.8
young comparison	7	$\bar{x}$=16.9	S.D.=4.7	$\bar{x}$=16.3	S.D.=9.2
old comparison	10	$\bar{x}$=14.8	S.D.=6.3	$\bar{x}$=17.5	S.D.=9.3
all comparison	17	$\bar{x}$=15.6	S.D.=5.6	$\bar{x}$=17.0	S.D.=9.0

The verbal aggression scores were found to be fairly similar for both the "male to female" and "female to male" categories. Male partners obtained a mean verbal aggression score of 20.3 for all treatment families and male partners obtained a mean verbal aggression score of 17.0 for all comparison families. In the "female to male" category, a mean for verbal aggression of 16.8 was obtained for all

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treatment families and a mean for verbal aggression of 15.6 was obtained for all comparison families. Standard deviation showed a large range of variation suggesting that the amount of verbal aggression varied greatly between families.

Although the mean for the two categories were closer together, in contrast to the physical aggression values, this research still revealed a tendency for the male partner to engage in verbal aggression more frequently than the female partner. Also, the means obtained for the verbal aggression scores were approximately twice as high as the means obtained for the physical aggression scores, which suggests that children in this study were exposed to very high levels of verbal aggression, in addition to the physical aggression they have witnessed.

In terms of what is already known about male batterers, the results obtained in the "male to female" categories of the verbal aggression scale were not surprising. However, the relatively high scores obtained by the mother may be of greater interest. Many of the mothers interviewed freely admitted to frequently using verbal aggression as a means of negative communication with their partners, despite the possible consequences to themselves. These same mothers

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said that an argument between themselves and their partners often started with verbal aggression by either one or both parties, but often ended with a physical assault by their male partner. Certainly, the results obtained from the CTS support the mother's statements that verbal aggression often leads to physical aggression.

Wolfe, Jaffe, Wilson, & Zak (1985) studied 102 violent families and 96 non-violent families. They found that non-violent families scored a mean of 2.1 for total physical aggression utilizing the CTS. Violent families scored a mean of 27.8 for total physical aggression utilizing the CTS. Unfortunately, Wolfe et al. study did not include figures for verbal aggression. However, in contrasting the means for physical aggression obtained in our study with the Wolfe et al study, one can argue that exposure to family violence does have an impact on children from violent homes.

Finally, children's total exposure to violence between parents can be calculated by summing the means for both the "male to female" and "female to male" categories. A total physical aggression mean of 14.9 was obtained for all treatment families and a total physical aggression mean of 14.4 was obtained for all comparison families. A total verbal aggression mean of 37.1 was obtained for all

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treatment families and a total verbal aggression mean of 32.6 was obtained for all comparison families. In all categories, the results collected indicate exposure to high levels of intra-spousal violence.

Responses were also collected from the mothers for the "parent to child" category on the physical aggression sub-scale of the CTS. The "parent to child" aggression sub-scale measured physical aggression from "mother to child" and "father to child". Again, scoring was done in a similar manner to the previous two sub-scales, except that since there were only nine items on the scale, the maximum possible score for physical aggression by "parent to child" was 54.

The following table reveals the results obtained.

Table 4

Mothers' Report: Physical Aggression Against Child, utilizing Conflict Tactics Scale (CTS)

Group	N	Mother to Child		Father to Child	
young treatment	5	$\bar{x}$=5.6	S.D.=4.0	$\bar{x}$= 7.0	S.D.=3.5
old treatment	6	$\bar{x}$=5.0	S.D.=3.5	$\bar{x}$=13.7	S.D.=8.2
all treatment	11	$\bar{x}$=5.3	S.D.=3.5	$\bar{x}$=10.6	S.D.=7.1

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young comparison	7	$\bar{x}$=9.0	S.D.=5.7	$\bar{x}$=11.6	S.D.=3.6
old comparison	10	$\bar{x}$=9.5	S.D.=4.9	$\bar{x}$=10.6	S.D.=7.7
all comparison	17	$\bar{x}$=9.2	S.D.=5.1	$\bar{x}$=11.0	S.D.=6.2

The physical aggression scores were found to be higher for the "father to child" category than the "mother to child" category with fathers scoring a mean value of 10.6 for all treatment families and fathers scoring a mean value of 11.0 for all comparison families. In the "mother to child" category, a mean of 5.3 was obtained for all treatment families and a mean of 9.2 was obtained for all comparison families.

It is important to observe that means for physical aggression by mother against the child may have been higher, had it not been for the lower values received by the treatment families. This researcher is at a loss to explain why there would be so large a difference as was found between the overall mean for the treatment families and the overall mean for the comparison families. Therefore, any interpretation that mothers from violent homes tend to rely less on physical aggression than do fathers, would be invalid based on the data generated from this study. This finding can be considered tentative at best.

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It was interesting to note that the mothers reported that both parents throw things, push, grab, slap, and hit their children when their children anger them. Another caution which appears appropriate to mention is that the mothers' memory might be faulty and the mothers might tend to over report "father to child" aggression and under report "mother to child" aggression.

Another interesting fact generated by this research was that the frequency of physical aggression by the male adult against his female counterpart was almost identical to the mean generated for the frequency of physical aggression directed against the child by the father. This finding has suggested support for the idea that a violent father may tend to control all family members through the use of physical intimidation. However, it can also be argued that both the mother and the father from a violent home often resort to utilizing physical means to control the behaviour of their children.

By summing the means of physical aggression for "mother to child" and "father to child", the total physical aggression for "parent to child" can be obtained. A mean of 15.9 was obtained for physical aggression by parent against the child for all treatment families and a mean of 20.2 was

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obtained for physical aggression by parent against the child for all comparison families. It was interesting to note that these figures were similar to values obtained in the Wolfe, et al. (1985) study of violent versus non-violent families for violent families. The Wolfe, et al. (1985) study also measured the frequency of total physical aggression by the parent against the child.

Data on the frequency of child abuse was collected to control for child abuse as a possible intervening factor. The pre-test mean did not produce any significant results, for either young, old, and/or all treatment groups. This result suggested that child abuse was not a significant intervening factor in this study.

The data generated by the Conflict Tactics Scale has supported the idea that children from violent homes are very frequent witnesses to both psychological and physical abuse between their parents. Sometimes physical abuse is also directed against children by either one, or both, of their parents. Thus, there appears to be a great deal of opportunity for children in violent homes to observe, learn, and integrate violence as a form of problem solving in their own lives. These results have added further evidence to

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support the theorists who have formulated that violence may be learned within the family setting and that a child who is raised in a violent family of origin is at risk of becoming either abused and/or violent when raising their own family.

4.2. MOTHERS' REPORT ON THEIR CHILDREN'S PARTICIPATION IN TREATMENT GROUPS

Treatment group children's responses to their group experience, as well as the responses of their mothers are presented in this chapter. These responses are presented through the use of descriptive statistics and verbatim reporting. Both mother and child were asked if the child enjoyed participating in the treatment groups and what the child learned from their group experience. The mothers were asked if there had been any changes in the child's behaviour since their child started the treatment group. In addition, the children were asked to compare their experience in the treatment group with other small group experiences in which they may have participated in the past. Finally, each child in the treatment group was asked if he/she would like to participate in a similar group in the future if they were given the opportunity.

The results were most encouraging. Only one mother

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(9.1%) felt that her child had not enjoyed the group. Only 18.2% of the mothers reported that their child enjoyed the group a little, while 72.7% of the mothers reported that their child enjoyed the group a lot. The following table summarizes the results obtained to this inquiry.

Table 5

Mothers' Report: Children's Enjoyment of the Group

Group	N	Not at all		A little		A lot	
young	5	N= 0	0%	N=2	40%	N=3	60%
old	6	N= 1	16.7%	N=0	0%	N=5	83.5%
all	11	N=10	9.1%	N=2	18.2%	N=8	72.7%

The only negative comment came from a mother who said that her daughter had wanted to quit the group. This mother indicated that her daughter "was the kind of person that quits (all) activities". However, her daughter declared that she "liked the group a lot". In this particular case, the researcher felt that the mother was projecting some of her negative feelings on to her daughter, as this mother presented to this researcher as an individual with very low self-concept as well as a history of mental illness. Indeed, the group therapists reported that in their evaluation, this girl came from a highly dysfunctional

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home and the group therapists felt this young girl was also showing clinical symptomatology reflecting the psychopathology present within the family.

It is interesting to note 40% of the mothers with children in the seven to ten year old age group reported that their children only enjoyed the group a little. Both of these parents reported that although their children appeared to like the group once they arrived at group, these children experienced some hesitancy about getting prepared for and getting ready to go to group. Thus, these two mothers felt their children were somewhat anxious about attending the group. It was these mothers' belief that discussing emotionally laden material was difficult for their children. Both of these parents said that there was an increased amount of acting out behaviour present in their children during the initial stages of the group, but that this acting out behaviour had ceased by the final stages of the group. The fact that the children's acting out behaviour had ceased by the end of the group sessions suggests that the group intervention had a therapeutic impact on these two children.

However, 72.7% of the mothers reported that their children enjoyed the group a lot. The responses which the

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mothers gave as to why they believed that their children had enjoyed participation included:

> "he seemed to have enjoyed himself when he got home, (he) enjoyed the activities, socializing with other children... the group atmosphere seemed to have a positive effects".

> "she did not seem upset when she got home".

> "being involved with other children was good for him".

> "they liked the skits".

> "she said she liked going to group".

Finally, it is interesting to note that the mother's response to the inquiry dealing with their child's enjoyment of the group was highly concordant with the responses provided by the children.

It is interesting to note that the mothers did not mention the theme of family violence in their responses to this inquiry. However, this was not surprising since most of the mothers also reported that their children did not

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talk with them about the material covered in the group sessions. For the most part, the children kept their experiences and activities about the group to themselves and did not disclose what happened in the group to their parents. This was in response to the therapists' request to respect the confidentiality of group. This may also have been a means by which the group members express their commitment to the group and identify their group experience as being their own. The mothers had been told during the pre-group interview that the children would be asked to maintain confidentiality, and it does not appear that the mothers attempted to obtain information about the group from their children during the progress of the group sessions.

This tendency by the children of the treatment groups to keep the discussions within the group among themselves, and maintain the confidentiality of the group was also reflected in how the mothers responded to the inquiry soliciting information from the mothers about what the mothers believed their children had learned from their group experience. The following table summarizes the results obtained from the mothers' responses to this inquiry, "What do you think your child learned from the group?"

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Table 6

Mothers' Report: Did Child Learn from Group Experience

Group	N	Yes		No		Don't Know	
young	5	N=3	60.0%	N=0	0%	N=2	40.0%
old	6	N=1	16.7%	N=0	0%	N=5	83.3%
all	11	N=4	36.4%	N=0	0%	N=7	63.6%

Sixty-three point six percent of all the mothers reported that they did not know what their children had learned from their group experience. These mothers said that they did not know what their child had learned from the group experience because their child did not talk about the group experience with them.

An interesting finding was that 83.3% of the early adolescent children did not talk to their mothers about the group experience while only 40% of the latency aged children did not talk about their group experience with their mothers. Although this research did not focus on investigating the causes of why there was such a difference in the pattern of responses between the two age groups, the reasons why this might be the case can be conjectured. This result may reflect developmental issues and differences between the two age groups. The older children entering the

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adolescent years and starting to assert their independence from their parents might be less willing to discuss personal issues with their parents. As adolescents proceed through the adolescent years, the peer group becomes more important, and they begin the process of differentiating from their family of origin. The adolescent years are often characterized by parent-child conflict and this would further reduce the likelihood that adolescent children would approach their parents with discussions about family conflict.

Conversely, 60% of the mothers of latency-aged children reported that their children did learn something from their participation in the treatment group. It appears that the latency-aged children were far less reluctant to talk about their group experiences with their mothers than their older counter-parts. This might also be explained in terms of children's developmental phases. As latency-aged children, these children have not started the developmental task of starting to differentiate from their family of origin. Also, latency-aged children still tend to seek the approval of their parents. Thus, these children are more dependent on their families for emotional support and thus more likely to disclose to their mothers what was happening to them in group.

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Generally, it may be said that the topic of family violence may be very difficult for the children to talk about at home because it may be emotionally very painful for them and the children may have learned that family violence is not to be talked about at home. Talking about family violence at home might be going against family norms which deny the existance of family violence. In this way, the family secret surrounding family violence is maintained as is the corresponding assaultive behaviour between the children's parents.

Other possible interpretations must also be considered. The experience of having participated in the group may have had a cathartic effect for these children which may have reduced the need for the children to talk with their mothers about family violence in the homes. Finally, it may just be that these children were not in the habit of talking about family violence in the home, as they may perceive this as normal behaviour in their home, and that participation in the group did not impact on the children enough to cause a change in the children's pattern of communication at home.

The children might also believe that to discuss family violence at home might risk the displeasure of their

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parents. On the other hand, the group provided the children with a "safe haven" where the children could talk about how they respond to and deal with incidents of family violence.

The mothers of children in the latency aged treatment group provided the following responses to the inquiry which asked them to identify what their children had learned from their participation in the treatment group. One mother reported that her child showed "an increased knowledge of where to go and what to do when there is violence....(he has) learned not to get himself involved and get into a fight between them (parents)". A single parent stated that her son "learned to talk more" with her and that she was pleased to see her son being more expressive with her. Interestingly, Pressman (1984) has identified that one of the goals of working with latency aged children from violent homes is to get these children to talk more. Another mother reported that her latency aged child has "learned to be more co-operative" with her parents. This response suggests that this child has learned to problem solve more effectively, as well as learning more effective modes of social interaction with her parents.

The mothers were also asked to indicate if their child's behaviour and conduct had changed since their child started

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the group. The mothers were asked if their child's behaviour had worsened, remained the same or improved. The following table indicates the results reported by the children's mothers to this inquiry.

Table 7

Mothers' Report: Changes in Child's Behaviour

Group	N	Worse		No Change		Better	
young	5	N=0	0%	N=0	0%	N=5	100%
old	6	N=0	0%	N=3	50%	N=3	50%
all	11	N=0	0%	N=3	27.3%	N=8	72.7%

It is interesting to note that although 63.6% of the mothers reported that they did not know what their child had learned from the group experience, 72.7% of the children's mothers stated that their children's behaviour had improved since their children participated in the treatment group.

No mothers reported that their children's behaviour had worsened and only 27.3% of the mothers reported that their children's behaviour remained the same. Interestingly, all of the children whose behaviour was reported as remaining the same were in the early adolescent treatment group.

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The fact that an impressive 72.7% of the mothers reported that their children's behaviour was better since their child started the group has provided strong descriptive evidence that the group intervention resulted in positive behavioural changes in treatment children which were observable by their mothers. Thus, this finding can be interpreted as providing descriptive evidence to support the primary hypothesis which predicted that the children's mothers would report observing behavioural improvements in their child's conduct following treatment.

This researcher can only conjecture why only 50% of the early adolescent's mothers reported behavioural improvements in their children. As discussed previously, parent-child conflict is often present in families with adolescent children, and if this was the case among children in this study, then this may colour the mother's perception of her child's behaviour. Also, in the adolescent age group, there was one mother who had three children in the early adolescent group and she reported that the behaviour of all her children remained the same.

It is also interesting to note that these three children were all males. Wolfe, Jaffe, Wilson, and Zak (1985) in their research have suggested that mothers find it more

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difficult to perceive changes in male children. This is because there is an identificatiion between a male child and the aggressor (violent male) by the mother which tends to block an ability by the mother to perceive positive changes in male children. However, in this particular case, the mother presented to this researcher as having a very warm, supportive and caring relationship with her male children. The mother's apparent relationship with her children would tend to contradict Wolfe, et al.'s (1985) ideas regarding the mother's identification with the aggressor being operative within this family. Therefore, to suggest that the above mentioned factor contributed to the results obtained by the early adolescent treatment group with regard to this mother's report, that her children's behaviour did not change, remains purely speculative.

Since 72.7% of the mothers reported that their children's behaviour had improved since their children's participation in the group, the possibility that the mothers exhibited a tendency to report positive behavioural changes, when this may not have been the case must also be considered. In an attempt to control for this tendency as a possible intervening variable, the mothers were also asked to describe how their child's behaviour had changed. One mother reported that her eight year old child was showing

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greater attachment to both parents:

> "he discusses things....he talks about things that bother him. He is really making an effort and I am starting to love my son more....I like the way he is dealing with things. He is also more co-operative picking up on chores and being more helpful. He does not throw temper tantrums since going to the group".

Another mother reported that her young son "has been more co-operative and he has been in better control of himself - in particular, his anger".

The mother of one of the girls in the early adolescent treatment group also mentioned the theme of co-operation. "she is more co-operative and she gets along better with her dad". Another mother presented the following picture of her child:

> "he handles things better. He realizes that it was not his fault if parents fight and he no longer gets involved in battles between parents....He became more sensitive towards others' feelings. He is easier to talk to. He now thinks about things and his capacity for understanding is much improved. He seems calmer,

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no longer as frustrated".

The verbal reports provided by the mothers of children in the treatment group suggest that their children showed improvements in areas of cognitive and behavioural skills, child adjustment and child conduct. Also, there was evidence that indicates that the children in the treatment groups exhibited improvements in their social functioning within the family unit. All reports given by the mothers can be interpreted as providing descriptive evidence that supported the primary hypothesis being investigated in this research. It can also be argued that the children's adaptive thinking processes have been enhanced by group treatment which has resulted in these children exhibiting increased problem solving abilities which help them function more effectively within their families. However, caution must be noted in how these descriptive findings can be interpreted. Since only descriptive statistics were utilized to analyze the mothers' responses, this data cannot justify any inferences about a cause-effect relationship existing between improvements in child behaviour reported by the mothers with children in the two treatment groups and group treatment per se.

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4.3. MOTHERS' DESCRIPTIONS OF THE FAMILY AND CHILDREN

Hughes and Hampton (1984), Rosenbaum and O'Leary (1981), Wolfe, Jaffe, Wilson, and Zak (1985) all argue that children who have been exposed to violence between parents are at risk of developing adjustment difficulties. It has been hypothesized that increased vulnerability to adjustment difficulties may be the result of the children's exposure to violent role models, exposure to the discord that accompanies wife abuse, or having to cope with the fear that their mothers and the children themselves may be physically injured (Rosenbaum and O'Leary, 1981). Also, children from violent homes are more likely to have experienced a disruption in their school, friends, neighbourhood, and usually a significant adult in their lives. Therefore, the crisis experienced by children from violent homes may be equal to the crisis faced by their mothers (Alessi and Hearn, 1984), (Hughes and Hampton, 1984).

Marital disruption was reflected in the mother's report of their families' marital status. Only 27.3% of the treatment children and 23.5% of the comparison children were from intact families at the time of the pre-group interview. Sixty-three point six percent of the treatment children and 47.1% of the comparison children were from single parent

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families. Nine point one percent of the treatment children and 29.4% of the comparison children came from reconstituted families. In addition, 32.1% of the mothers reported that they had been separated from two or more live-in relationships. The mother's marital status was found to be a significant intervening variable in this study (x^2 =13.97, df=1, p<.001). This finding has supported the view of researchers who have found that violent families are at risk of separation.

It is interesting to note that when interviewing with intact and reconstituted families, both parents were invited to attend the pre and post-group interviews. However, no fathers attended during the pre-group interviews and only one father attended with his spouse during the post-group interviews. Perhaps this says something about the division of family tasks in families in which parental violence is present. However, this researcher also recognized the fact that most interviews were conducted during regular office hours during which many fathers would have been at work.

The data supplied by the mothers in this research supports the idea that children in violent homes have suffered from other stressors apart from witnessing assaultive behaviours. Researchers such as Sameroff,

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Siefer, & Zak (1982) and Rutter (1979) have argued that it is not the specific type but the amount of stressors present that most impact on a child. Thus, the summative effects of stressors present in children from violent homes could be considered more damaging than merely witnessing the effects of assaultive and or psychological abusive behaviour. For example, Walker (1979) has suggested that maternal effectiveness may be impaired in violent families and that the children from these homes may suffer from inconsistent, understimulating, or inappropriate attention from either or both parents. Other researchers have started to look at factors which mitigate against the negative effects of stressors that impact on a child's life. For example, Garmezy & Rutter (1983) identified three protective factors that mitigate against the negative impacts on a child's life. These include: a) individual attributes of the child, b) support within the family and, c) support figures outside of the family system. For example, it can be argued that if a good parent-child relationship exists with at least one parent, then this tends to mitigate against the negative effects of witnessing family violence.

Mothers were asked to identify how close they feel their child was to them and to their fathers on a scale from one to seven. The mean of all children for closeness to mother

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was 5.4 and the mean for closeness to father was 4.3.

It was not surprising to see that the mothers rated their children closer to them than to their fathers. One must be aware that the mothers may have a tendency to over report their closeness, and under report the father's closeness. However, it is more likely that the closer degree of closeness to mothers was a reflection of the prime care taker role mothers normally occupy. In part, this may also have resulted from the protective feelings that children from violent homes have towards their mothers (Pressman, 1984). However, when one considers the T scores generated by the Achenbach Child Behaviour Checklist, it does not appear that closeness to mother had a dramatic impact on mitigating against behavioural and social adjustment difficulties in the children from violent homes who participated in this study. This study did not discover any evidence to support Garmezy & Rutter's contention.

Despite the possibility that the mothers may be under-estimating their child's attachment to the father, the overall means of 4.3 suggests that an important bond exists between children and their fathers. Finally, it must be added that the closeness to parent measure appears to be a very weak measure if it is used to measure the quality of

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relationship between parent and child. Just because this measure showed attachments between parent and child, this does not guarantee that there is a healthy parent-child relationship.

In families in which separation had occurred, the children often experienced infrequent contact with the absent parent. The mothers were asked how often their children saw their absent parent. The following table reports on the results obtained to this inquiry.

Table 8

Mothers' Report: Frequency of Visits with Absent Parent

Group	N	Weekly		Bi-monthly		Monthly		Sporadic		No Contact	
		N	%	N	%	N	%	N	%	N	%
young treatment	3	1	33.3%	1	33.3%	0	0%	1	33.3%	0	0%
old treatment	5	0	0%	0	0%	2	40%	0	0%	3	60%
all treatment	8	1	12.5%	1	12.5%	2	25%	1	12.5%	3	37.5%
young comparison	5	1	20%	1	20%	0	0%	2	40%	1	20%
old comparison	8	1	12.5%	1	12.5%	1	12.5%	5	62.5%	0	0%
all comparison	13	2	15.4%	2	15.4%	1	7.7%	7	53.8%	1	7.7%

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It was found that only 25% of children from treatment families and 30.8% of the children from comparison families had any regular and adequate contact with the absent parent (regular and adequate contact was defined as being at least two visits per month). In all but two families, the absent parent was the father. In two of the comparison families, daily care and control of the child was exercised by the father. It is interesting to note that the mother's response to this inquiry was almost identical to the frequency of visits with the absent parent reported by the children. Dennis (1980) has written that lack of contact with the absent parent is often viewed by the child as rejection by the absent parent.

Since the violent families studied in this research were found to be at a great risk of experiencing marital separation, it was not surprising to find that the children were also exposed to more than one significant male role model. The mothers were asked to identify the number of significant male role models their children had been exposed to. The following table illustrates the results reported by the mothers.

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Table 9

Mothers' Report: Number of Significant Male Models in Child's Life

Group	N	$\bar{x}$	S.D.
young treatment	5	1.2	0.4
old treatment	6	1.0	0.0
all treatment	11	1.1	0.3
young comparison	7	2.1	1.1
old comparison	10	2.1	1.0
all comparison	17	2.1	1.0

The mean number of significant male models all treatment had been exposed to was 1.1 and mean number of significant male models all comparison children had been exposed to was 2.1. This researcher can not account for the difference between comparison and treatment children except to suggest that this likely was the result of utilizing a non-random experimental design.

For all children, a mean of 1.7 significant male model was obtained. Forty-six point four percent of all the children had been exposed to two or more male models. The

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number of male models these children had been exposed to was found to be a significant intervening variable (x^2 =10.36, df=1, p<.002). The children in this study were found to likely to have been exposed to more than one significant male role model.

The results obtained from the Conflict Tactics Scale showed that children from violent homes are often exposed to violent male role models. The mothers were asked to identify the number of violent male role models the children had been exposed to. The number of violent male models the children had been exposed to was found to be a significant intervening variable (x^2=5.03, df=1, p<.05)

All the children were exposed to a mean of 1.0 (S.D.=0.4) violent male models. Ten point seven percent of the children had been exposed to at least two violent male models. It is interesting to note that 7.1% of the mothers reported that this children had not been exposed to a violent male model. The inquiry dealing with the number of violent male models was subject to the mother's perception of what constitutes violent behaviour. The mothers were not made aware of the researcher's definition of family violence. Therefore, it was not surprising to find that two mothers reported that their children had not been exposed to

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any violent males.

Children from violent families have not only dealt with the losses associated with separations and infrequent contact with the absent parent, but these children have also dealt with the frequent moves that may result from marital separation or the tendency of violent families to isolate themselves from the community by moving frequently. Jaffe, Wolfe, Wilson, & Zak (1985) reported that there was a mean of 7.4 changes in family residence since the birth of the families' first child in a sample of 102 violent families, but a mean of only 4.6 moves in a sample of 96 non-violent families they studied. The mothers in this study were asked to report on the number of changes in family residence since the birth of their first child. The following table illustrates the results obtained to this inquiry.

Table 10

Mothers' Report: Frequency of Moves

Group	N	$\bar{x}$	S.D.
young treatment	5	3.8	3.1
old treatment	6	8.0	3.5
all treatment	11	5.7	4.1

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young comparison	7	3.4	4.0
old comparison	10	5.3	4.3
all comparison	17	4.5	4.7

The mothers reported a mean of 4.9 moves since the birth of their first child for all the children that participated in the study. An inspection of the standard deviation revealed that there was considerable variation from one family to another. Previous research by Jaffe, et al. (1985) suggested that violent families move more frequently. However, Jaffe's sample represented an urban sample rather than the rural community which constituted the population of families in this study.

The number of moves the children made was found to be a significant intervening variable (x^2=24.41, df=1, p<.001). Forty-two point eight percent of the children had moved five or more times. Thus, this study found that children from violent homes moved frequently, although there was considerable variation from family to family.

The following table reports on sex distribution of the children that participated in this research.

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Table 11

Mothers' Report: Children's Sex

Group	N	Male		Female	
young treatment	5	N=4	80%	N=1	20%
old treatment	6	N=3	50%	N=3	50%
all treatment	11	N=7	63.7%	N=4	36.3%
young comparison	7	N=5	71.4%	N=2	28.6%
old comparison	10	N=5	50%	N=5	50%
all comparison	17	N=10	58.8%	N=7	41.2%

Sixty-three point seven percent of the children in treatment group were male and 36.3% of the children in the treatment group were female. Fifty-eight point eight percent of the children in the comparison group were male and 41.2% of the children in the comparison group were female. The children's sex was not found to be a significant intervening variable.

The mean age of children in the latency aged treatment group was 8.6 years and the mean age of latency aged children in comparison group was 9.1 years. The mean age of children in the early adolescent treatment group was 12.7

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years and the mean age children in the early adolescent comparison group was 12.1 years.

The mothers also reported on their total family income at the time of the pre-group interview. Total family income varied greatly, ranging from $0/annum to $57,000/annum. Family income was not found to be a significant intervening variable.

The $0 income was reported by a separated parent who had recently entered Chatham-Kent Women's Shelter with her children and had not applied for social assistance at the time of the interview. The $57,000 income was reported by two mothers living with their spouses who operated their own businesses. The following table summarizes the results obtained.

Table 12

Mothers' Report: Total Family Income in Canadian Dollars

Group	N	$\bar{x}$ income	S.D.
young treatment	5	$11,000	8,287
old treatment	6	$12,567	4,854
all treatment	11	$11,940	6,052

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young comparison	7	$24,800	11,150
old comparison	10	$17,823	7,992
all comparison	17	$20,813	18,116

The mean incomes and standard deviation varied greatly between both treatment and comparison families. Thus, there was considerable variation in income from family to family. However, it is important to note that 58.3% of all families had total family incomes of less than $12,000/annum. The mean income for all families was $17,327. Income was not found to be a significant intervening variable. The family income data has supported the view that family violence is not restricted to certain economic groups, but may affect families regardless of income bracket.

The mothers were asked to report on the number of years of formal education they had completed. Mother's level of education was found not to be a significant intervening variable. No mother reported having an education of grade seven or less. On the other hand, there were no university graduates among the mothers that participated in this research. Sixty-six point seven percent of mothers that had children in the comparison groups had completed some secondary school, while 26.7% had successfully completed

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high school, and 6.6% had completed some post-secondary schooling. From mothers who had children in the treatment group, we learned that 9.1% had completed elementary school, 63.6% had completed some high school and 27.3% had successfully completed high school.

4.4. CHILDREN'S REPORT BASED ON THEIR PRE GROUP INTERVIEW

A great deal of valuable information was obtained from the children who participated in this study. This data was generated from the interview schedule administered to the children during their pre-group interview.

The children's perception of positive and negative parental behaviour was assessed using a modified version of the Parent Perception Inventory (1981). If the children viewed their parents in a positive light, we would expect to find high scores in positive perception and low scores in negative perception. The following table illustrates the results obtained.

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Table 13

Children's Pre-Group Report: Parent Perception Inventory

Group	N	Positive Perceptions			
		Towards Mother		Towards Father	
		$\bar{x}$	S.D.	$\bar{x}$	S.D.
young treatment	5	10.8	2.5	8.2	3.8
old treatment	6	13.8	3.9	9.0	6.5
all treatment	11	12.5	3.5	8.1	5.2
young comparison	7	12.3	1.4	11.0	3.5
old comparison	10	11.8	2.8	11.7	2.5
all comparison	17	12.0	2.3	11.4	2.9

Group	N	Negative Perceptions			
		Towards Mother		Towards Father	
		$\bar{x}$	S.D.	$\bar{x}$	S.D.
young treatment	5	6.0	1.6	9.2	5.1
old treatment	6	9.0	3.7	9.0	5.3
all treatment	11	7.6	3.2	9.1	4.9
young comparison	7	8.9	2.8	8.7	3.0
old comparison	10	9.3	3.6	5.8	4.7
all comparison	17	9.1	3.2	7.0	4.2

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A mean of 12.5 was obtained for positive perception of mother's behaviour for all treatment children and a mean of 12.0 was obtained for positive perceptions of mother's behaviour for all comparison children. The means for positive perception of father's behaviour were 8.6 for all treatment children and 11.4 for all comparison children. The mean values for positive perceptions of either parent were relatively low suggesting that the children perceived neither parents' behaviour in a particularly positive manner.

Mean values for children's negative perceptions of mother's behaviour were 8.9 for all treatment children and 9.1 for all comparison children. The mean negative perception of father's behaviour was 9.1 for all treatment children and 7.0 for all comparison children. There did not appear to be an appreciable difference between mother and father in the children's negative perception of their parent's behaviour. However, there was a slight tendency for all children to view their mother's and father's behaviour in a more positive than negative light, although this result was far from conclusive.

The results attained from the parent perception inventory suggested that the children perceived their

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parent's behaviour as having a fairly negative impact on them. Based on these results, it can be argued that the children had little trust in their parent's ability to meet their needs. The low positive perception scores suggested that both mothers and fathers present as being somewhat inattentive to the children's needs. These results have supported the findings of previous researchers who have found that in a violent family, both the batterer and the assaulted spouse have limited capabilities to meet their children's needs due to preoccupation with their own needs. There was also evidence to suggest that the impact of being exposed to living in a home in which family violence occurs prohibits strong positive perceptions of either parent's behaviour from occurring.

Levine (1975) suggested that children from violent homes commonly display anxiety disorders such as worrying, anxiety, specific fears, and phobias. Therefore, one could expect that children from violent homes would score high on a fear survey. A modified version of a fear survey developed by David Wolfe of the University of Western Ontario (unpublished manuscript) was completed by all children in this study. The information from children provided the following results:

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Table 14

Children's Pre-Group Report: Wolfe's Fear Survey

Group	N	$\bar{x}$	S.D.
young treatment	5	60.0	12.1
old treatment	6	43.2	17.6
all treatment	11	50.8	17.0
young comparison	7	54.3	13.9
old comparison	10	46.0	15.6
all comparison	17	49.4	15.1

A total overall fear survey mean of 50.0 was obtained for all subjects. These values indicated that the children experienced a very high level of fear. For example, a child who scored 45 on the fear survey would have scored a mean of one (indicating he experienced fear some of the time) for each item on the fear survey. This research supported the findings of researchers who have found that children from violent homes are subject to all sorts of anxiety disorders and fears.

The child's stress as it related to life events experienced by the child was measured by an adapted version

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of Johnson and McCutcheon's Life Events Check List. As with the fear survey, this measure was administered in both the pre and post-test situation. The purpose of utilizing this measure in both the pre-group and post-group interviews was to control for the frequency and intensity of negative life events as perceived by the child. A one-tailed comparison t-test was used to test for a significant interaction with time. Negative life events was not found to be significant intervening variable.

The mean for negative life events experienced by treatment children was 16.0 and the mean for negative life events experienced by comparison children was 23.2. The mean values for both treatment and comparison children were relatively high suggesting that children from violent homes experience a high level of negative stress in their lives. The stress levels experienced by children from violent homes suggest another factor which may be operative in accounting for research findings which suggest violent homes are at risk of developing behavioural maladjustments.

It is the feeling of researchers that social supports serve as a buffer against some of the stresses faced by children from violent homes. A paired comparison t-test to test for group differences did not reveal a significant

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finding. The following table illustrates the results obtained:

Table 15

Children's Pre-group Interview: Utilization of Social Supports

Group	N	$\bar{x}$	S.D.
young treatment	5	6.3	3.3
old treatment	6	5.9	3.2
all treatment	11	6.1	3.3
young comparison	7	8.6	2.9
old comparison	10	7.4	1.3
all comparison	17	8.0	2.2

The social supports mean for all treatment children was 6.1 and the social supports mean for all comparison children was 8.0. The results show that the children perceived that there was only a moderate level of social supports available to them. Therefore, these children did not perceive members of their nuclear and extended families; and members of the community such as teachers, other significant adults, or their friends as being able to help

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when they are facing a difficulty and need help.

Since the children did not appear to perceive their environment as a supportive one, it was not surprising to find that the children do not talk with others about their parents' fighting and or separation. During the pre-group interview, 61.9% of children who came from homes in which a separation had occurred reported that they did not talk about their parents' separation with their friends and 69.2% of all the children reported that they did not talk about their parents' fighting with their friends.

The children also provided evidence that they view their families and their environment as frightening places in which hitting and fighting are a normal pattern in life. During the pre-group interview, the children were asked, "How often do people in the same family hit each other?" Sixty-nine point two percent of the children stated that members of the same family hit each other some of the time and 30.8% of the children said that members of the same family hit each other a lot. The children were also asked, "How often do strangers hit each other?" Twenty-one point four percent of the children said that strangers never hit each other; 57.2% said that strangers hit each other some of the time; and 21.4% of the children said that strangers hit

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each other most of the time.

Although the children perceived their environment as being a violent place, the children were able to intellectualize that hitting was not acceptable behaviour. One hundred percent of the children said that it was "not OK for a man to hit a woman".

When the children were given a series of fixed alternatives, 100% of the children indicated that it was not appropriate for a man to hit a woman if she stays out too late or a woman keeps the house too messy. Only 7.1% of the children indicated that it would be "OK for a man to hit a woman if she does not do as she is told" and 25% of the children responded that it was "OK for a man to hit a woman if she has been drinking". However, 55.5% of the children agreed that it was "OK for a man to hit a woman in self-defense".

Interestingly, only 78.6% of the children indicated that it was "not OK for a woman to hit a man". Twenty-one point four percent of the children did say there are times when it was OK for a woman to hit a man. In response to fixed alternative responses, 82.1% of the children believed it was acceptable for "a woman to hit a man if he stays out too

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late"; 89.2% of the children believed it was acceptable for a woman to hit a man if "he keeps the house too messy"; 81.1% of the children said it was "OK for a woman to hit a man if he does not do as he is told and 70.4% of the children said it was "OK for a woman to hit a man if he has been drinking". Seventy point four percent of the children said it was acceptable for a woman to hit a man if she did so in self-defense.

It does appear that although the children could intellectualize that it was not appropriate for their parents to hit each other, in reality, there were many situations in which hitting behaviour was acceptable. These results could be interpreted as supporting the view that to some extent, these children have already internalized their acceptance of hitting behaviour.

Fifty-seven point two percent of the children stated that it was "OK for a parent to hit a child". The children were able to identify situations when it was OK for a parent fo hit a child. Fifty-seven point two percent said it was "OK to hit a child if he does not do as he is told"; 28.6% said it was "OK to hit a child if he is late in coming home"; 21.4% said it was "OK to hit a child if he has been in trouble at school"; 55.6% said it was "OK to hit a child

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for talking back"; and 28.6% of the children identified other situations where it was "OK for a parent to hit a child". Among other reasons given were: for stealing, breaking things, hitting one's brother or sister, and doing things one should not do.

On occasions when their parents did physically discipline them, 65.4% of the children indicated that they "deserved to be hit". These results were similar to the findings obtained during the pilot study in August of 1985. In both the pilot study and this research, the children were able to identify situations in which hitting behaviour was acceptable. The descriptive results attained in the pilot study and this research provided evidence to support the notion that observing parental spouse abuse may cause a child to perceive violence towards woman as normative and legitimate (Rosenbaum, & O'Leary, 1981).

The children in this study were able to articulate that hitting behaviour between men and women was not acceptable. This researcher has conjectured that there were two forces at play which accounts for this result. First, it appears that there may have been an effect from previous counselling experiences. With the exception of one family that was referred to this project, all the families had some previous

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counselling assistance from either the Chatham-Kent Woman's Centre, The Lester B. Pearson Centre for Youth and Children, The Kent County Task Force on Family Violence, or the Children's Aid Society of Kent County. It was likely that the children who participated were made aware of the fact that hitting behaviour within the family setting was unacceptable through educational and or counselling efforts made by the referring agencies. Another example which suggested that these children had previous exposure to education about family violence was the children's response to the inquiry which asked the children to identify what they would do in an emergency. Sixty-seven point nine percent of the children knew what to do in an emergency situation, whether it be calling a relative, neighbour, police or calling for medical help. Most children were able to provide a phone number of someone they could call in case of an emergency situation. In contrast, only 44% of the pre-test children were able to identify what to do in an emergency situation in the pilot study conducted in Guelph.

Secondly, although the children were able to intellectualize that hitting between parents was unacceptable, this in itself does not mean the children avoid violent behaviours in their own day to day affairs. During the pre-group interview, the children were asked to

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report on how they deal with their own feelings of anger and confrontation with their own peers.

The children were asked,"how often do you get mad?" Eighty-two point one percent of the children said that they get mad sometimes and 17.9% of the children said they get mad often. Sixty point seven percent of the children reported they yell, scream, or swear sometimes, and 28.6% of the children said they yell, scream or swear often. Sixty point seven percent of the children agreed that they sometimes fight, hit or punch when they get mad and 14.3% of the children agreed that they often fight, hit or punch when they get mad. Seventy-eight point six percent of the children reported that they respond with threats when teased by children their own age. Fifty-three point six percent of the children reported that they strike out and hit another child their own age when that child teases them. Seventy-eight point six percent of the children claimed they hit another child if that child takes something from them. Interestingly, only 33.3% of the children reported that they hit another child their own age if that child hits them first.

The children's responses to inquiries about what they do when they become angry has provided evidence to suggest that

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they frequently imitate methods used by their parents to resolve conflicts. These results have provided further descriptive evidence to support the work of Steinmetz (1977), and Bellack & Antell (cited in Steinmetz, 1977, p. 29) who believe that children from violent homes imitate the methods used by their parents to resolve conflict when interacting with their peers. Also, it can be argued that when another child hits a child from a violent home first, their tendency not to strike back and withdraw is consistent with adopting the role of a victim within a violent family system.

Fifty-seven point one percent of the children responded that they were able to recall incidents when either their mother or father have asked them for advise when they were experiencing a problem. In addition, 50% of the children indicated they sometimes helped their mother when she was unhappy, while 46.4% of the children indicated they often helped their mother when she was unhappy. Correspondingly, 37.5% of the children said they sometimes helped their father when he was unhappy and 39.3% of the children said they often helped their father when he was unhappy. One hundred percent of the children reported that they worried about their mother and 78.6% of the children reported that they worried about their father.

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The observations cited above can be interpreted in the following way. The finding that a large number of children experienced situations in which they have been asked for advice by their parents suggest that some role reversal and role confusion may be present in violent families. The children may be elevated to meet their parents' needs. Placing their children in a parentified role would not only be inappropriate behaviour on the part of a parent, it may also encourage the children to take responsibility for their parents' behaviour. Thus the burden of guilt experienced by children from violent homes would be increased, resulting in further confusion for the child. This would increase the risk of maladjustment on the part of the child since children are not able to cope developmentally and cognitively with a parentified role at their age.

Further evidence to suggest that children from violent homes accept feelings of responsibility for the welfare of their parents was obtained when one examined the children's responses to the inquiry of how often the children perceive themselves as helping their parents when their parents are unhappy. The children said they listen to their parent's problems, talk with their parents about their problems, offer advise, and spend time with their parents when they

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are unhappy. The children also stated they help their parents by cheering them up, telling them a joke, asking them what's the matter, or looking after the other children. The following table describes the children's responses to a fixed alternative inquiry that dealt with how the children help their parents when they are unhappy.

Table 16

Children's Pre-group Interview: How I Help My Parents When They Are Unhappy

Alternatives	N	%
Listen to their problems	28	75.0%
Talk to them	28	82.1%
Give advise	28	67.9%
Do extra housework	28	82.1%
Give them a hug	28	84.1%
Other	28	71.4%

It was not surprising to find that the children worry more about their mother than their father. This may be in part due to the fact that most children had less contact with their fathers, and most mothers have responsibility for daily care of the children. However, a more likely

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interpretation would be that children from violent homes become very protective of their mothers whom the children witness being abused.

Forty-six point two percent of all children indicated that they can tell when their father will hit their mother. These children reported that their father "raises his fist", "his face gets red", "he starts throwing things", "he pushes and shoves mom", "he threatens to hurt her and the kids", "he gets drunk". Thirty-four point eight percent of the children said that they can tell when their mother will hit their father. "She gets nervous", "she starts to yell, scream and swear". Two children said they had not seen their father hit their mother and five children said they had not seen their mother hit their father. One child reported that "they fight after I go to bed". During the pre-group interview, several male children stated that they feared they would become like their father when they grow up. The evidence provided by the children from violent homes showed that without appropriate intervention, the fear expressed by these young children may become a reality.

Some children admitted to getting into the middle of their parents' arguments. They may act out, or try to separate their parents during a fight. Children who were

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willing to become this involved in their parents' fight, clearly place themselves in a position of risk. This can also be interpreted as an act in which the children are taking responsibility for their parents' behaviour.

The children no longer living with their father were asked if the amount of time spent with their father was just right, too much or too little. Despite the low level of contact with their absent parent, 61.9% of the children said that the amount of contact with the absent parent was just right, while 33.3% of the children indicated that there was not enough contact with the absent parent and only 4.8% of the children declared that visits with the absent parent were too frequent. To some extent, it does appear that children choose sides with their mother after their parent's separation.

From information solicited from the children, we see that children from violent homes hold traditional and stereotyped view of male/female roles. Children were asked to identify what kind of jobs men were good at and what kind of jobs women were good at. Their responses were evaluated in such a manner which allowed this researcher to determine if the children's responses were typical of stereotyped responses. Seventy-one point four percent of the children

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responded with stereotyped responses to the inquiry "what kind of jobs are men good at?" and 78.6% of the children gave stereotypical response to the inquiry "what kind of jobs are women good at?" Men were described as being good at factory work, truck driving, as being good scientists, computer persons, builders, policeman and fireman. Women were described as being good at mothering, clerking, housekeeping, nursing and waitressing.

When asked if the opposite sex could do that job, only 71.4% said this was possible, although in today's society, more and more adults are choosing non-traditional occupational roles, and indeed most jobs can be occupied by either sex.

The children's responses reflected the traditional value system stereotyped by male superiority in career choices and female superiority in at home activities. Further, researchers such as Pressman (1984) and Sinclair (1985) have identified that traditional perceptions of male/female roles are common in violent famailies.

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4.5. CHILDREN'S REPORT ON THEIR PARTICIPATION IN THE TREATMENT GROUPS

As was noted previously, the children in the two treatment groups were asked how much they enjoyed participating in the group sessions. The following table demonstrates the results obtained to this inquiry:

Table 17

Children's Report: Enjoyment of the Group

Group	N	Not at all		A little		A lot	
young	5	N=0	0%	N=1	20%	N=4	80%
old	6	N=0	0%	N=0	0%	N=6	100%
all	11	N=0	0%	N=1	9.1%	N=10	90.9%

It is interesting to note that none of the children indicated they did not enjoy their participation in the group. A surprising 90.9% of the children reported that they enjoyed the group a lot, while 9.1% or one child indicated he enjoyed the group a little.

Thus, 100% of the children and 90.9% of the mothers

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indicated that children enjoyed the group. There appears to be a very high degree of correspondence between the observation of the mothers and the report made by the children. These results were similar to the results obtained during the pilot group study held in Guelph during August of 1985. Further evidence to suggest that the children enjoyed participation in the group came from attendance figures at the group sessions. No child was absent for more than two of the ten sessions. The attendance was much better than anticipated. Many of the families who participated could be characterized as being highly dysfunctional in their presentation to this researcher, and thus, poorer rates of attendance were expected. When a child was absent, it was for legitimate reasons such as illness or the family being out of town.

The children's own words are probably the best evidence of showing what they liked most about the group. The following comments were made by the children about the group. These included:

"I liked talking with others and the games (refers to role plays)"

"I liked looking at feelings"

"I liked the role-playing. I also liked the drama of

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the situation"
"I liked the T.V. (appearing on videotape) and friends"
"I enjoyed the skits - acting them out" and
"I liked the boys".

The children were also asked what they did not like about the group. Most of the children refused to give any negative comments. In part, this may be accounted for by a feeling that they were expected to give a positive response. This researcher attempted to control for this response by including the following instruction to the children:

"Most everyone has experiences they like and dislike in groups. It is perfectly OK to talk about what you did not like. Knowing what you did not like helps us to plan for better groups in the future".

One child indicated that the sessions were "too long - it was hard to sit still for so long". Also, two children from the early adolescent group said that they did not like having the sessions on Saturdays, because groups interfered with their Saturday play time.

Based on the mother's and children's reports that the children enjoyed themselves and positive attendance noted by

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children participating in the group, it can be argued that both parents and the children made a concrete commitment to the treatment groups. It can be hypothesized that the group model utilized in the treatment groups was successful in meeting the children's need to the extent that the children attended groups regularly and in some way found the group experience to be a meaningful one for them. Clearly, the group experience had something to offer to each of the children. This appears to have resulted in the children being able to deal with and work through some of the painful emotional experiences associated with the family violence, as well as improving the children's problem solving skills and enhancing the children's adaptive thinking processes. Although not included in the interview schedule, this researcher asked each child if they would repeat the group program if given the opportunity to do so. Ninety point nine percent of the children (all but one) indicated they would like to repeat the experience.

It is the contention of this researcher that these positive reports were realized primarily because of two factors. First, the co-therapists were successful in creating a warm, accepting environment in which they provided adequate amounts of emotional nourishment to the participants. This enabled the children to reach out to

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each other, draw on their own ego strengths, and then engage each other in a self-help process, as well as a learning experience. Secondly, it appears that credit must be given to the developmental group work model which was utilized in both groups. The fact that this model recognized the developmental progression which groups experience, as well as being able to be responsive to the developmental needs of the children participating in the group probably contributed to the children's perception that this was an enjoyable experience and that the group experience was a meaningful one for them.

The children were also asked to identify how much they had learned from the group experience. The following table illustrates the results that were obtained to this inquiry:

Table 18

Children's Report: How Much Children Learned From Groups

Group	N	Not at all		A Little		A Lot	
young	5	N=0	0%	N=0	0%	N=5	100%
old	6	N=0	0%	N=1	16.7%	N=5	83.3%
all	11	N=0	0%	N=1	9.1%	N=10	90.9%

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Ninety point nine percent of the children reported that they learned a lot from the group experience, while only 9.1% (one) of the children reported that they learned a little. It is interesting to note that these percentages were identical to the percentages reported to the inquiry dealing with child's enjoyment of the group. The possibility exists that the children were responding to this inquiry in a manner which they felt the researcher wanted to hear, rather than communicating what they actually felt. This researcher knew of no way of controlling for this possibility, except by adding an inquiry to the interview schedule which asked what it was that the children had actually learned from their group experience. However, it may have been that the children's perception of their group experience as being an enjoyable one was also equated with the children's perception that this was a group experience in which they could and did learn a lot.

During the post-group interview, each child who had participated in a group was asked to identify three things he/she had learned from the group. Nearly all children (except two) were able to identify three things which they had learned from the group without any difficulty. This finding provided support to the children's perception that they "learned a lot" from their participation in the group.

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The children's responses reflected the themes which were covered in the weekly group sessions (see Appendix A). The children presented their responses in an open and spontaneous manner which suggested that the children were not responding to this inquiry in a manner reflective of giving a "robot" memory response. The following is a sample of the responses provided by the children during the post-group interivew:

"I learned to be in greater control of myself"

"It's not good to fight"

"You don't have to hit people when you are mad"

"There is another way besides fighting"

"Talk about your problems"

"Where to go when mom and dad are in a fight"

"I learned about feelings, respecting people and caring"

"How to control anger"

"How to express feelings"

"Different people like to do different things"

"How to act better"

"Learned some new games"

"How to laugh more"

"Learned that I can talk to people when they cry"

"When someone feels down, you can ask them what's wrong"

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"You can talk to people who are hurt"

"Don't need to let people touch my privates (from a young girl who had been touched sexually by a schoolmate)"

"That I'm not alone"

"How to make friends"

"About divorce"

"Not to get involved when mom and dad are fighting," and perhaps one of the most poignant,

"You don't have to be scared all the time. There are others to help you".

It appears that from this wide range of responses that the children who participated in the two treatment groups were able to address areas of concern and meaning to themselves as well as gain useful information about family violence and how family violence impacts on their lives. The children's responses also provided evidence to suggest that the children learned some more effective emotional and practical strategies to deal with the real life situations which these children experience on a day to day basis in their homes.

The children were asked to compare their experience in the treatment groups with other groups in which they had

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participated in the past. Only 54.6% of the treatment children responded that they had been in any other group situation other than at school. Thus, for 46.4% of the treatment children, this represented their first small group experience. This finding has provided further support for the literature which suggests that violent families are often socially isolated (Walker, 1979). This finding also has provided support for the Pressman (1984) and Sinclair (1985) argument that group treatment is a necessary component of any treatment plan for children from violent homes.

For the six children who had at least one small group experience, 83.3% reported that their experience in the treatment group was a better experience for them than participation in other small groups. One child reported that this experience was just about the same as his previous experience. None of these children reported that this group experience was a "worse" experience for them.

Based on the findings presented by the mothers and the children who participated in the treatment groups, it can be argued that participation in the treatment groups did have a positive impact on the emotional well-being, cognitive and behavioural skills of the participants. Although the mother's and children's statements suggest support for the

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primary hypothesis, no generalizations or inferences about cause-effect relationships can be made by just examining the mother's and children's evaluative responses, since these statements were only descriptive in nature.

4.6. RESULTS OBTAINED BY TESTING PRIMARY HYPOTHESIS FOR STATISTICAL SIGNIFICANCE

The major hypothesis of this research was that "Children who have been exposed to family violence will show improvements in cognitive and behavioural skills following treatment, compared to no treatment comparisons. In addition, a broad spectrum of child adjustment and parents report will reflect improvements in child conduct". Therefore, it was expected that children in both age groups would show an improved ability to handle emergency situations and parental conflict; possess increased knowledge of safety skills; take less responsibilities for parental violence and parental behaviour; display more appropriate behaviour in responding to their own anger; and possess changed perceptions about when hitting behaviour was either acceptable or not acceptable.

It was reasoned that these changes would take place as the result of the children's increased ability to utilize

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problem solving skills which the group experience afforded its participants. In addition, children in the treatment groups were given the opportunity to express their own feelings and concerns about growing up in a violent family.

An improvement in cognitive and behavioural abilities was defined as "an enhancement in the children's adaptive thinking processes (problem solving abilities)". Also, if it was found that the children would respond more appropriately to crisis situations they may encounter, it was assumed that the children's cognitive and behavioural skills had improved.

In the interview schedule administered to the children in both the pre and post-group interviews, all the children were asked how they dealt with specific situations. For example, they were asked what they did if their mom and dad were arguing and/or hitting. Specifically, the children were asked, "What do you do when dad is hitting mom and you are in the same room?", "What do you do when dad is hitting mom and you are in a different room?", "What do you do if mom and dad hit you?", and "What do you do in an emergency?"

The children were also asked how they handled specific situations involving their peers. Specifically, the

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children were asked, "What do you do when a child your own age teases you?", "What do you do when a child your own age takes something away from you?", and "What do you do when a child your own age hits you?"

A third category of inquiries dealt with situations when hitting behaviour was either acceptable or not acceptable. Specifically, children were asked, "When is it OK for a man to hit a woman?", "When is it OK for a woman to hit a man?", and finally, "When is it OK for a parent to hit a child?" With the exception of the item which asked the children what they did in an emergency, the children were asked to respond to a number of fixed alternative responses to each question asked. Each response was then scored as to whether the child had made an appropriate or inappropriate response. The total number of appropriate responses were then totalled for each category. This allowed the researcher to make pre and post-group comparisons. The three categories that were identified were responses that dealt with fighting behaviour, responses that dealt with hitting behaviour, and responses that dealt with peer conflict. For example, if a child responded that he/she left the room when his/her mom and dad were arguing, this would be scored as an appropriate response. If the child responded that he/she stayed in the same room when his/her mom and dad were arguing, this was

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scored as an inappropriate response. The rationale utilized in this example was that it would be inappropriate for children to put themselves in a position of risk, or potentially become involved in a parental argument. Also, if a child responded that it is not OK for a man to hit a woman if she kept the house too messy, the child's response would be scored as an appropriate one. If the child responded by saying it was OK for a man to hit a woman if she kept the house too messy, this child's response would be scored as an inappropriate response. The rationale utilized in scoring this item was that it would be inappropriate for either a man or a woman to hit each other in any circumstances, except if the hitting took place within the context of self-defence. Similarily, if a child responded that he/she hit a child who teased him, this would be scored as an inappropriate response, but if the child said he/she left the situation, this would be scored as an appropriate response. The rationale for scoring this item was that it is inappropriate to respond to situations involving peer conflict by resorting to physical aggression.

As mentioned previously, the children were asked "What do you do in an emergency?" This item was scored in the following way. If the child identified two or more things he/she could do in an emergency situation, the child was

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identified as having given an appropriate response. If the child identified no options or only one thing he/she could do in an emergency situation, the child's response was scored as an inappropriate response. The rationale utilized was that it is important for children to have several helpful strategies available to them when they find themselves, or others, in an emergency situation. If post group scores improved significantly among treatment children, this was considered adequate evidence that cognitive and behavioural skills of the children in the treatment groups had improved. Data collected from the latency aged children, the early adolescent children, and all the children as a whole were analyzed.

The first category of responses dealt with how the children dealt with witnessing fighting behaviour. A significant difference in the positive direction was found between treatment and comparison children for latency aged, early adolescent and all children as a whole.

The second category of responses dealt with the children's responses to conflict situations involving their peers. No significant difference was found between treatment and comparison groups for either the latency aged, early adolescent, and all children.

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The third category of inquiries dealt with the children's responses to situations when hitting is either acceptable or unacceptable. No significant differences were found between treatment and comparison groups for either the latency aged, early adolescent or all children.

The following tables illustrate the results obtained from examining the children's responses to the categories of inquiries utilized to measure the change in cognitive and behavioural abilities.

Table 19

Children's Report: Means Measuring Cognitive and Behavioural Abilities

Category	Group	N	Pre-Group $\bar{x}$	Post-Group $\bar{x}$
Fighting	young treatment	5	17.0	24.0
Behaviour	young comparison	7	24.0	19.2
	old treatment	6	18.5	19.6
	old comparison	10	17.1	15.4
	all treatment	12	17.8	19.6
	all comparison	16	19.9	16.9

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Peer	young treatment	5	15.2	15.7
Conflict	young comparison	7	15.7	14.9
	old treatment	6	15.2	13.5
	old comparison	10	12.9	10.5
	all treatment	12	15.2	14.1
	all comparison	16	14.1	12.3
Hitting	young treatment	5	11.2	11.0
Behaviour	young comparison	7	11.0	11.6
	old treatment	6	13.7	13.8
	old comparison	10	10.2	10.8
	all treatment	12	12.5	12.7
	all comparison	16	10.5	11.1

Table 20

Change of Anova Scores: Children's Responses to Fighting Behaviour Inquiry

Category	Group	N	df	t-values	$p<.05$
Fighting Behaviour	young treatment vs young comparison	12	10	2.180	.05

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old treatment vs old comparison	16	14	1.820	.05
all treatment vs all comparison	28	26	2.916	.005

These results provided some evidence to suggest that children in the treatment groups have improved in their cognitive and behavioural abilities involving situations, while children in the comparison groups had actually shown a deterioration in their cognitive and behavioural abilities. Treatment children exhibited an improved ability to deal with situations involving fighting behaviour, whereas children from the comparison groups showed a decreased capacity to deal with situations involving fighting behaviour. An inspection of the change of anova data for the fighting behaviour category revealed statistical significance due to treatment at the .05 level of probability for both the latency aged and early adolescent children. For all children participating in the study, statistical significance at the .005 level of probability was achieved. An inspection of means showed that latency

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aged treatment children scored a mean of 17.0 in the pre-group interview and a mean of 24.0 in the post-group interview. Latency aged comparison children scored a mean of 24.0 in the pre-group interview and mean of 19.2 in the post-group interview. The early adolescent treatment children achieved a mean of 18.5 in the pre group interview and a mean of 19.6 in the post-group interview. The early adolescent comparison children achieved a mean of 17.1 in the pre-group interview and a mean of 15.4 in the post-group interview. All treatment children achieved a mean of 17.8 in the pre-group interview and a mean of 19.6 in the post-group interview. All comparison children achieved a mean of 19.9 in the pre-group interview and a mean of 16.9 in the post-group interview. Thus, it can be concluded that children from the treatment groups acquired the skills necessary to cope more effectively with fighting behaviour, while control group children showed deterioration in their ability to cope effectively with fighting behaviour.

However, there were no significant differences due to treatment found for the second or third category of inquiries. Apparently, social work practice with groups, as utilized in this demonstration project had no effect on the ability of the children to deal more effectively with stressful peer relationships. This was perhaps not

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surprising, since the focus of the group sessions were not to improve peer relationships, but rather to cope more effectively with family conflicts, in particular, fighting behaviour.

Table 21

Change of Anova Scores: Children's Responses to Peer Conflict Inquiry

Category	Group	N	df	t-values	p<.05
Peer Conflict	young treatment vs young comparison	12	10	0.198	N.S.
	old treatment vs old comparison	16	14	0.387	N.S.
	all treatment vs all comparison	28	26	0.468	N.S.

No statistical significance due to treatment was found for the category of inquiries that dealt with when hitting

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behaviour was either acceptable or when hitting behaviour was not acceptable.

Table 22

Change of Anova Scores: Children's Responses to Hitting Behaviour Inquiry

Category	Group	N	df	t-values	p<.05
Hitting Behaviour	young treatment vs young comparison	12	10	0.276	N.S.
	old treatment vs old comparison	16	14	0.257	N.S.
	all treatment vs all comparison	28	26	0.490	N.S.

It appears that the children's responses to this category of inquiries were more dependent on the children's belief systems. Thus, it may be argued that changing the children's belief systems may acquire more intensive

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intervention than provided by this group experience. Also, it can be argued that changes in this area would be difficult to achieve in a short period of time, since the children in the treatment groups did not have enough time to integrate the knowledge and skills acquired during their participation in the group into their own ways of behaving. Thus, it may have been more beneficial to provide an incubation period prior to administering the post-group interview, so that the children had the opportunity to integrate their new learning and acquire improved problem solving skills. Also, if this category of responses measured the children's perceptions and attitudes, rather than their cognitive abilities and behavioural skills, it can be argued that this measure exhibited poor construct validity, since the measure may not have measured what it was intended to measure.

Also, there was an experimental design difficulty which surfaced during the analysis of this data which was not expected by this researcher. The children's pre-group responses for the second and third categories scores were much higher than were expected. Since the data generated by the pre-group interview for both treatment and comparison group resulted in higher values than anticipated, this left very little room for measuring positive changes in the post-

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group interview. In part, this may have accounted for an inability to obtain statitically significant results after the post-group interview had been completed. Also, all the families that participated in this study had been exposed to previous counselling experiences. The effects of previous counselling may have contributed to the knowledge possessed by the children in this study, thus accounting for the relatively high means obtained during the pre-group interview by children from both the treatment and comparison groups about the events being investigated.

For example, approximately 50% of the children were referred by the Chatham-Kent Women's Centre. Since this agency is known for working with both the abused woman and her children, the children referred from this agency already may have had some knowledge about reacting appropriately to family violence rather than starting with a clean slate and no knowledge about family violence. Therefore, the extent to which previous exposure to family violence may have confounded the results in this research project remains undetermined.

The assumption made in examining the three categories of data presented was that these items adequately measured the children's ability to problem solve in both crisis and other

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stressful situations. The possibility that this was not the case must be discussed. It can be argued that the third category of responses was heavily influenced by the children's perceptions and attitudes of a situation, rather than being a report of their actual behaviour. If the suggestion that the category of responses dealing with hitting behaviour measured the children's perceptions and attitudes, rather than their actual behaviour is accurate, then this interpretation may also be given to data generated by the categories which measure the children's responses to witnessing fighting behaviour and the children's responses to situations involving peer conflict.

It may have been that these inquiries did not measure the children's cognitive and behavioural skills, but rather measured the children's perceptions about given situations. If this study were replicated in the future, this researcher would refine the instruments used to measure the children's cognitive and behavioural abilities. Perhaps instruments such as the MEPS (Shure & Spivak, 1976b) might be a more appropriate instrument to measure the children's adaptive thinking processes. Problem solving abilities can be tested using the MEPS, which asks the child to provide solutions to actual difficulties encountered in interpersonal situations. Thus it has appeared that the criteria used to measure

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change in cognitive and behavioural skills may have had good face validity, but poor construct validity. Unfortunately, the difficulties with construct validity were not discovered during the preliminary testing of the children's interview schedule during the pilot study which took place in Guelph, Ontario during the summer of 1985.

The primary hypothesis also predicted that treatment children would show improvements in a "broad measure of child adjustment", which can be utilized to measure changes in child conduct. The Achenbach Child Behaviour Checklist was selected as the instrument to measure changes in child conduct, since this standardized instruments is capable of measuring the overall level of behavioural problems of children. No significant interaction due to treatment was found for any of the groups in this research. However, an inspection of the means obtained from the mother's completion of the Child Behaviour Checklist in both pre and post-group interview generated changes in a positive direction, towards an improvement in overall child adjustment, for both treatment and comparison groups.

The following table illustrates the means obtained for the Child Behaviour Checklist during the pre-group and post-group interviews.

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Table 23

Mothers' Report: Means for Achenbach Child Behaviour Checklist

Group	N	Pre-Group $\bar{x}$	Post-Group $\bar{x}$
young treatment	5	70.20	64.00
young comparison	7	69.14	65.71
old treatment	6	73.83	66.17
old comparison	10	69.50	62.10
all treatment	11	72.18	65.18
all comparison	17	69.35	63.59

The test for main effect of occasions revealed a significant difference existed across time since treatment and comparison groups made systematic shifts in the same direction. Table 24 illustrates the results that were obtained.

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Table 24

Mothers' Report: Anova for Occasions Test Utilizing the Achenbach Child Behaviour Checklist

Group	N	df	t-value	p<.05
young treatment vs young comparison	12	11	3.767	.005
old treatment vs old comparison	16	15	3.685	.005
all treatment vs all comparison	28	27	4.984	.000

In interpreting these results, it must be noted that the Achenbach Child Behaviour Checklist was designed to be administered once every six months and since there was a mean lapse time of only four months between the administration of pre and post-group interviews, the reliability of these results may be questionable.

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The test for main effect for occasions showed a marked improvement in the overall level of child adjustment for both treatment and comparison children. Both treatment and comparison groups attained mean scores either well within, or on the border of the clinical range during the pre group interview. During the post-group, mean scores were either within the normal or just on the borderline of the normal range for this instrument. The result produced by this instrument suggests that factors occuring outside of the context of the group experience played an important part in accounting for the results that were attained. Such factor, or factors, appeared to be operating simultaneously within both treatment and comparison groups. A possible interpretation for this data is that there was a decrease in the frequency of marital violence in both the homes of treatment and comparison group children.

In the post-group interviews, mothers of children from intact and reconstituted families for both treatment and comparison families were queried about the frequency of intra-spousal violence during the duration of the group treatment program. Fifteen point four percent of these mothers reported that marital violence had stopped since the children started the group. Sixty-nine point one percent

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said that intra-spousal violence had decreased since the children started the group. Fifteen point four percent of the mothers reported that the level of violence was just about the same as before the treatment groups began, and none of the mothers reported an increase in intra-spousal violence. Based on these results, it can be argued that merely intervening in the family system acts in such a way as to exert some form of social control which may help to reduce the frequency of marital violence during the period of any intervention. Further evidence to suggest support for the belief that intra-spousal violence decreased during the period of the treatment groups was obtained from Wolfe's Fear Survey. Although the results obtained from Wolfe's Fear Survey are more fully discussed later in this chapter, both treatment and comparison children showed a marked decrease in the level of overall fear experienced at post-testing. This corresponded with the mother's report that there were reduced levels of violence between parents during the period of this research project.

The Achenbach scores also showed improvements in the post-testing situations for both treatment and comparison groups. A significant interaction was found for main effect for occasions. If there was less violence in the homes of the subjects, then one could argue that this would impact in

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a positive manner on Achenbach scores for all children, as indeed was the case.

Although statistical significance due to treatment was not shown, an inspection of the differences between the means of both treatment and comparison groups revealed that greater differences were achieved for the treatment groups than for the comparison groups. Therefore, this can be interpretated as providing some evidence to suggest that treatment did have a positive impact on the children's behaviour. The high mean scores for total behaviour problems received by both treatment and comparison groups during the pre-group interview supported the findings of previous researchers who found that children from violent homes are at risk for developing child maladjustments.

Finally, the primary hypothesis also predicted that the children's mothers would report an improvement in their children's conduct. From the post-group interviews administered to the mothers, we found that 100% of the mothers with children in the treatment groups reported either a little, or a lot of improvement in their child's behaviour, following treatment. This result has provided further evidence that social work group intervention with children from violent homes was an effective means of

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facilitating behavioural changes that fostered improvements in child conduct among the treatment group's participants.

In summation, this study generated some significant results indicating support for the primary hypothesis, although significance was not achieved for all measures. Thus the results can only be interpreted very tentatively. The data generated in examining the primary hypothesis did not allow this researcher to make any cause-effect statements. The major difficulty identified by an analysis of the data collected in testing the primary hypothesis appears to be the construct validity of the instruments utilized to measure changes in cognitive and behavioural skills among the study's subjects. If this study was to be replicated, further refinement of the instruments used to measure cognitive and behavioural changes is indicated. However, the data also showed results that the treatment children did make some measureable gains while the comparison children's ability to cope with family violence showed deterioration. This suggests that the group treatment modality utilized in this research had a positive impact on children from violent homes and was successful in meeting some of the needs of the children. Thus, social work group practice with children appears to hold promise for being an effective means of intervening with children

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from violent homes.

4.7. RESULTS OBTAINED BY TESTING SUB-HYPOTHESES FOR STATISTICAL SIGNIFICANCE

Four pairs of sub-hypotheses were tested. Each hypothesis was stated in terms of the alternative hypotheses predicting statistical significance. The alternative hypothesis Hi: $u1 - u2 > 0$ was tested against the null hypotheses Ho: $u1 - u2 \leq 0$. Each hypothesis was accepted or rejected at the .05 level of probability using a one-tailed test of significance. Significance was considered in the positive direction only. Paired comparison t-tests were utilized to test for, a) the main effect for groups, b) the main effect for occasions, and c) the main effect for interaction.

The pre-test interview administered to the children showed that children from violent homes experienced a high level of fear. The sub-hypotheses tested were:

> "There will be a significant reduction in the level of fear experienced by latency aged children in the treatment group, compared to no treatment comparisons, following treatment", and

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"There will be a significant reduction in the level of fear experienced by early adolescent children in the treatment group, compared to no treatment comparisons, following treatment".

A fear survey developed by David Wolfe, professor of psychology, at the University of Western Ontario was utilized in this research to measure the level of fear experienced by the children. The following tables illustrate the results obtained.

Table 25

Change of Anova Values for Wolfe's Fear Survey

Group	N	df	t-value	p<.05
young treatment vs young comparison	12	10	1.276	N.S.
old treatment vs old comparison	16	14	.883	N.S.

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all treatment vs all comparison	28	26	1.575	N.S. (.10)

Table 26

Anova for Occasions Test for Wolfe's Fear Survey

Group	N	df	t-value	p<.05
young treatment vs young comparison	12	11	3.952	.005
old treatment vs old comparison	16	15	2.445	.025
all treatment vs all comparison	28	27	4.483	.000

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No significant difference was found due to treatment, however, a significant effect for occasions was discovered. Thus, there was a corresponding reduction in level of fear for both treatment and comparison groups for both age groups. Therefore, it was likely that the reduction in level of fear experienced by the children was not due to the effects of treatment, but rather due to a lessening of violence in the home. This would account for a reduction in the level of fear experienced by both children in the treatment groups and children in the comparison groups. Thus, the alternative hypothesis was rejected and the null hypothesis accepted.

This researcher believed that a child's participation in a treatment group would act in a cathartic manner and reduce the children's negative perception of stressful life events. It was reasoned that if the treatment group was successful in providing the children with more coping strategies, this would act in such a way as to reduce the child's negative perception of stressful life events.

The following sub-hypotheses were formulated:

"There will be a significant reduction in latency aged children's negative perception of stressful life

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events, compared to no treatment comparison, following treatment", and

"There will be a significant reduction in the early adolescent children's negative perception of stressful life events, compared to no treatment comparisons, following treatment".

The following tables illustrate the results obtained.

Table 27

Pre and Post-Test Means: Children's Perception of Negative Life Events

	Pre-test		Post-test	
Group	N	$\bar{x}$ values	N	$\bar{x}$ values
young treatment	5	13.4	5	20.0
young comparison	6	26.3	6	18.9
old treatment	7	18.6	7	22.5
old comparison	10	26.3	10	26.1
all treatment	12	16.0	12	21.4
all comparison	16	23.2	16	23.0

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Table 28

Change of Anova Values for Children's Perception of Negative Life Events

Group	N	df	t-value	p<.05
young treatment vs young comparison	12	10	1.331	N.S.
old treatment vs old comparison	16	14	1.035	N.S.
all treatment vs all comparison	28	26	1.732	.05

No meaningful changes were obtained between pre and post-test means for any of the comparison groups. Between the treatment groups, both latency aged and early adolescent children showed an increase in mean scores for this measure. The test for main effect of interaction was significant for

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all children at the .05 level of probability, utilizing a one-tailed test for statistical significance. However, no statistical sigificance for treatment was found for either the latency aged or the early adolescent group. Thus, the results have suggested that error due to size-effect may influence the results obtained for the latency aged and early adolescent group. Therefore, when cumulative results for both groups were considered, statistical significance was attained.

The results obtained were opposite to what was expected, since the hypothesis being tested predicted that the means for perception of negative life events among treatment children would decrease, not increase. Thus, it can be interpreted that the effect of group treatment was to increase the children's awareness of negative life events to which they had been exposed. Thus, it can be concluded that children in the treatment groups started to think more about the situations they had experienced and thus were able to view their negative life experience from a more realistic perspective. Also, it can be argued that in order to test if the children improved problem solving abilities leads to a reduced perception of negative life events, it might be beneficial to test the children after a sufficient period of time has passed for the treatment children to integrate

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adequately the new coping strategies they have learned during treatment. If this study were to be replicated, it would be recommended that post-testing of treatment and control children be done six months after completion of the treatment groups. This would provide adequate time for integration of new learning to take place.

Previous research has suggested that children from violent homes tend to have very stereotyped and traditional perceptions of male/female roles. One of the focuses of the treatment groups was to examine male/female roles in our society and then help the children to develop more appropriate perceptions of male/female roles. To help test for change in the children's perception of male/female roles the following hypothesis were developed and tested in this study.

The sub-hypotheses were:

"There will be a significant improvement in the latency aged children's perception of sexual roles, compared to no treatment comparisons, following treatment", and

"There will be a significant improvement in the early adolescent's perception of sexual roles, compared to no

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treatment comparisons, following treatment".

Children were asked the following questions. How are boys different from girls? How are girls different from boys? What jobs are men good at? What jobs are women good at? Is it OK for the opposite sex to do that job? Is it OK for mother to work outside the home? Is it OK for father to look after the children?

Each response provided by the children to each item was tabulated and scored as being either an appropriate or inappropriate response. If the response to the item reflected a stereotypical view of male/female roles, the response was scored as being inappropriate. If the response reflected an androgynous or non-traditonal view of male/female roles, the item was scored as being appropriate. For example, a child who responded that it was not OK for a father to look after the children, would have the response scored as an inappropriate response, whereas a child who stated that it was OK for father to look after the children would have the response scored as an appropriate one. The child who said it was OK for a man to be an artist (an androgynous response) would be scored as having given an appropriate response, whereas a child who said it was OK for a man to be a truck driver (a stereotypical response) would

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be scored as having given an inappropriate response. The purpose was to find if the children would provide more non-sexist responses following treatment.

The total number of appropriate responses to all items dealing with sexual stereotyping was scored for each child in both the pre and post-group conditions. A main effect of interaction test was applied to the data to determine if there was any significant interaction due to treatment. No significant interaction due to treatment was found for either the latency aged, early adolescent, and all children's groups. An inspection of the means for each of the age groups showed virtually no change between pre and post-testing for either treatment or control groups.

This finding was not expected, but perhaps was not surprising. The alternative hypothesis was rejected and the null hypothesis was accepted. The results indicated that treatment was not effective in changing the traditional perceptions of male/female roles in children from violent homes. It can be argued that perceptions of male/female roles are deeply ingrained. According to Pressman (1984), sexist and traditional perceptions of male/female roles were prevalent among children from violent homes. This study supported this view, as well as supporting the view that

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changes in perceptions of sexual roles are very resistant to change.

Emery (1982) suggested that a warm relationship with at least one parent can mitigate, although not eliminate the effects of marital turmoil on children. Sandler (1980) reported that social supports moderates the effects of stress on children. Rutter & Garmezy (1983) found that good relationships with peers and with adults outside of the family tend to mitigate the effects of stress.

It was believed by this researcher that the children's participation in group treatment would result in these children being able to utilize social supports available to them to a greater extent. Therefore, the following sub-hypotheses were developed.

> "There will be a significant difference in the latency aged children's ability to utilize social supports when the children have a problem, compared to no treatment comparisons, following treatment", and

> "There will be a significant difference in early adolescent's ability to utilize social supports when the children have a problem, compared to no treatment

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comparisons, following treatment".

A shortened version of Procadano and Heller's Social Support Scale was utilized in this project. Each child was asked who he goes to for help and how often. The results obtained showed that there was no significant interaction due to treatment for either the latency aged, early adolescent, or all children in the study. Therefore, the null hypotheses were accepted and the alternative hypotheses were rejected. The results suggested that at the time of post testing, the children were not utilizing social supports available to them to a greater extent than at the pre group interview.

However, two children were notable exceptions. Two principals of local schools in Kent County Board of Education made a point of reporting to this researcher that these two children, who were participating in the treatment groups had started talking more to their teachers and to the principals about their problems at home. These two principals stated that the two children involved had been very quiet and withdrawn prior to their involvement in the group and these principals attributed the change in the children's behaviour to their participation in the group. These children were talking more about their family

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situation, and reaching out to other adults for help.

Another possible interpretation of the data generated by the social supports measure was that since post testing took place shortly after the end of the treatment groups, was that the children did not have sufficient opportunity to utilize the social supports in their environments, and thus were not able to report a significantly greater utilization of social supports at the time the post-group instruments were administered.

Despite the exposure to the group process, the children in the treatment groups continue to live in violent homes. Violent families are known to keep themselves socially isolated. This family condition may have had the effect of mitigating against the children's ability to utilize social supports. Also, it must be noted that actual family violence may have affected and thereby confounded any of the data generated during the children's testing sessions. There was no method available to control for the violence that may or may not have occurred in the home during the duration of the group sessions.

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4.8. SUMMARY

This chapter has presented the findings of this research. Descriptive data generated by the pre and post-interviews of both the mothers and children who participated in this study were presented. The results obtained from testing the primary hypothesis and sub-hypotheses were reported. It was found that social work practice with groups may be an effective means of intervening with children from violent homes, although the data did not enable this researcher to make any statements about cause-effect relationship between the independent and dependent variables identified in this study.

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Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

The objective of this project was to develop and test the effectiveness of a group intervention program for children ages seven to thirteen who come from violent homes. It was believed that social work practice with groups can be an effective means of helping children from violent homes to cope with their emotional and physical responses to the crisis they experience as a result of having been witnesses to parental violence. The intervention model and procedures utilized in this research project emphasize competence enhancement rather than treatment of specific behaviours or emotional problems, since the children were involved as a result of the behaviour of the parents, rather than their own behaviours.

The intervention was based on factors that relate to the effects of witnessing violence (conflict resolution skills, problem solving, attitude toward violence, coping skills) and factors that relate to research on how children cope with a variety of different family and life situations.

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The primary hypothesis was that children who have been exposed to family violence will show improvements in cognitive and behavioural skills following group treatment, compared to no treatment comparisons. In addition, it was hypothesized that a broad measure of child adjustment and mother's report would reflect improvements in the conduct of the child following treatment. Several sub-hypotheses were also tested.

The study subjects were 28 children who had been exposed to marital violence in their homes. Children were non-randomly assigned to either a treatment group or comparison group. There were two treatment groups, one for children aged seven to ten and another for children aged eleven to thirteen, as well as correspnding comparison groups. Measures were utilized in the pre-group and post-group intervention to determine the effectiveness of group intervention.

It was believed that this study was relevant to social work with the child and family since this project addressed adjustment difficulties faced by the child who has witnessed parental violence, as well as prevention of future difficulties these children might experience as adults or as

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parents in a family of their own. There was a recognition made in this study that any child who lives with violence, or the threat of violence, can be considered a child at risk due to the following:

- a man who abuses his wife may also abuse his children
- a woman who is abused may vent her anger and frustration on her children. In turn, the children may vent their own rage and frustration on each other or on themselves
- children may be accidently hurt when they try to stop the violence or protect their mother
- children witnessing wife assault in their home may grow up to be abusive husbands or assaulted wives.

This researcher believed that group work with children could help the child face, and deal with, his or her own anger as well as the alternatives to violence and helplessness that are the results of growing up in a violent home. Other issues that were addressed with children receiving group treatment were ambivalence, role expectation, expression of feelings and the development of appropriate self responsibility. The interventions were carried out utilizing the theoretical framework of the "Boston Model" of group development.

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Social work practice with children from violent homes was recognized as being one means available to social workers to help provide these children with the support they need and rightfully deserve. This researcher felt that in the past, the focus has been to supply services to the batterer and the abused women. As a result, group work with children from violent homes is a relatively new area and it was the hope of this researcher to help fill the void that exists in literature on the impact of intra-spousal violence on children from these families.

This chapter is divided into the following areas of discussions; a) summary and conclusions derived from the mother's report on pre and post-test instruments; b) summary and conclusions derived from the children's pre-group interview; c) summary and conclusions derived from the children's post-group interview; d) summary and conclusions reached by testing the primary hypothesis; e) summary and conclusions reached by testing the sub-hypotheses identified in this research; and finally, f) the study's recommendations.

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5.2. SUMMARY AND CONCLUSIONS OBTAINED FROM DEMOGRAPHIC DATA SUPPLIED BY THE SUBJECTS' MOTHERS

Descriptive information about the mother, family and child was obtained from the mother during her pre-group interview. The information collected from the mother in this research project allows for a comparison of research data with data which has already been collected by other researchers working with children from violent families.

The demographic information helped to produce a profile of what the children from violent homes experienced and thus helped the researcher to reach a better understanding of some of the family dynamics and adjustment difficulties that the children in this study have confronted on a daily basis.

A similar interview schedule was also administered to the mother in the post-group interview. However, the results from the mother's post-group interview were reported only when there was extra information which the post-group interview added. Since there was very little variation in the information received from the mother in the pre and post-group interviews, this suggested that the interview schedule administered to the mother was very reliable. Indeed, this was expected, since the demographic data

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collected from the mother was factual in nature and therefore not subject to subjective and interpretive perceptions. The only instruments administered to the mother which were based on the mother's perception were the Child Behaviour Checklist and the Conflict Tactics Scale. The Conflict Tactics Scale was not used in the post-test situation, but the mother did complete the Child Behaviour Checklist in the pre and post-group interviews. The data obtained from the Child Behaviour Checklist will not be reported in this section of the concluding chapter since this has been included in the discussion of the primary hypothesis. The interview schedule administered to the mother in the post-group differed from the pre-group interview only in that there were inquiries added in the post-group interview that dealt with the mother's perceptions about her children's participation in the treatment group.

It is interesting to note that when dealing with intact or reconstituted families, both parental figures were invited to attend the pre and post-group interview. However, no fathers attended the pre-group interview and only one father attended with his spouse during the post-group interview. Perhaps this says something about the division of family tasks in families in which parental

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violence is present. However, this researcher also recognized the fact that most interviews were conducted during regular office hours, during which many fathers would be at work.

Only 27.3% of the treatment families and 23.5% of the comparison families were intact families at the time of the pre-group interview. Sixty-three point six percent of the treatment families and 47.1% of the comparison families were single parent families. Nine point one percent of the treatment families and 29.4% of the comparison families were from reconstituted families.

In addition, 32.1% of all mothers reported that they had been separated from two or more live-in relationships. The mother's marital status proved to be a significant intervening variable in this study.

In families where separation had occurred, only 25.0% of children from the treatment groups and 30.8% of children from the comparison groups had any regular contact with the absent parent. In all but two families, the absent parent was the father. It was interesting to note that the children reported an almost identical frequency of visits with the absent parent as the frequency of visits reported

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by the mother. Both previous research and this study has suggested that violent families are at greater risk of marital separation.

Children from violent families not only have dealt with the losses associated with separation and infrequent visits with the absent parent, but also have dealt with frequent moves that may have resulted from marital separation and the tendency of violent families to isolate themselves from the community by moving frequently. In this project, the mothers reported a mean of 4.9 moves since the birth of their first child. Previous research by Jaffe, Wolfe, Wilson, & Zak (1985) showed that violent families move frequently. However, Jaffe, et al.'s sample represented an urban sample, rather than the rural community which constituted the population of families in the present study.

Since children from violent families are at a high risk of experiencing separation, there may also be numerous male models in their lives. A mean of 1.7 male models was found for the families in this study. Forty-six point four percent of the children in this study have had two or more male models. The number of male models was found to be a significant intervening variable, suggesting that the number of male models is a significant factor that can affect the

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adjustment of a child.

Exposure to violent male models was also found to be a significant intervening variable. The children were exposed to a mean of one violent male model. Ten point seven percent of the children had been exposed to two or more violent male models. According to the mothers' reports, their children have been exposed to both verbal and physical abuse between parents. The children have witnessed their parents insulting each other, sulking, crying, and doing something to spite each other. The children were also exposed to seeing their parents pushing, grabbing, shoving, hitting, kicking and beating each other.

The aggression sub-scale of the Conflict Tactics Scale administered to the mother was utilized to generate data determining the frequency of physical and verbal abuse. The violence scores were found to be higher for the "male to female" category than the "female to male" category. A mean value of 11.0 for all treatment families and 10.1 for all comparison families were obtained for the "male to female" category. For the "female to male" category, a mean of 3.9 was obtained for all treatment families and a mean value of 4.5 was obtained for all comparison families. The finding that "male to female" violence is more frequent than "female

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to male" violence is consistent with previous findings which has shown that battered women are at risk from their partners.

The verbal aggression sub-scale of the Conflict Tactics Scale revealed a mean value of 20.3 for all treatment families and 17.0 for all comparison families for the "male to female" category. For the "female to male" category, a mean value of 16.8 was achieved for all tratment families and 15.6 for all comparison families.

The data generated from the verbal aggression sub-scale indicated a slight tendency for the male partner to engage in verbal violence more frequently than the female partner, however, these differences were not substantially significant. However, the verbal aggression scores were approximately twice as frequent as the physical aggression scores, which suggests that children from violent homes are exposed to very high levels of verbal aggression between their parents. It was interesting to note that many mothers freely admitted to using verbal aggression as a means of communicating with their partners, despite the possible consequences to them. These mothers stated that incidents often started as a verbal argument between spouses, but ended with a physical assault by their male partner. In

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their study of violent and non-violent families, Jaffe, et al. (1985) obtained a total physical aggression mean of 27.8 for violent families and 2.1 for non-violent families. In this study, a total physical aggression mean of 14.9 was obtained for all treatment families and a total physical aggression mean of 14.4 was obtained for all comparison families. A total verbal aggression mean of 37.1 was obtained for all treatment families, and a total verbal aggression mean of 32.6 was obtained for all comparison families.

The frequency reported by the mothers may have been subject to two biases: 1) the mothers memory may have been faulty, and 2) the mothers may have under reported the frequency of their own violence and over-estimated the frequency of their husbands' violence. However, the "frequency of physical violence" scores tend to support the mothers' contention that verbal altercations often lead to physical fights.

The results obtained from the Conflict Tactics Scale showed that children from violent homes were exposed to very high levels of physical and verbal aggression between their parents. These results have added further descriptive evidence to suggest that violent behaviour is learned in the

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home. If the children in this study model the behaviour learned at home in their own relationships, they are then at risk of becoming abusers or abused women in adulthood.

Responses were also collected for the frequency of physical violence directed by the parents at the child. The physical aggression scores were found to be higher for the "father to child" category, than the "mother to child" category. Fathers had a mean value of 10.6 for physical aggression against the child for all treatment families and a mean value of 11.0 for all comparison families. In the "female to male" category, a mean of 5.3 was obtained for physical aggression against the child by the mother for all treatment families and 9.2 for all comparison families. It was interesting to note that the means for male physical aggression against the female are almost identical to means for physical aggression against the child. These results can be interpreted as providing descriptive support for the notion that violent fathers tend to control all family members through the use of physical power, and this would add further evidence to suggest that children themselves are at risk of physical abuse.

The mean age of children in the younger treatment group was 8.6 years while the mean age for the younger comparison

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group was 9.1 years. The mean age of children in the older treatment group was 12.7 years and the mean age for the older comparison group was 12.1 years.

Mothers also reported their family's income during the pre-group interview. Yearly family income reported by the mothers ranged from $0/annum to $57,000/annum. However, 58.3% of the families in this study had incomes of $12,000/annum or less. The mean family income of all treatment children was $11,940 and the mean family income of all comparison children was $20,813. The income data suggested that family violence was not restricted to certain income groups, but rather may affect families regardless of their level of income.

Mothers' level of education also showed a wide range. Mothers with children in the comparison group reported that 66.7% completed some secondary schooling, 26.7% completed high school and 6.6% completed some post-secondary schooling. Mothers with children in the treatment group reported that 9.1% had completed elementary school, 63.6% had completed some high school, 27.3% completed secondary school and no one had completed any post-secondary education.

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The children's sex was not found to be a significant intervening variable. Sixty-three point seven percent of the treatment children were boys and 36.3% girls. Fifty-eight point eight percent of the comparison children were boys and 41.2% of the comparison children were girls.

Mothers were asked to rank how close their child was to them and how close they felt their child was to their father. On a scale of one to seven, the mean closeness to mother for all children was 5.4 and the mean for closeness to fathers for all children was 4.3. The results obtained showed that children were closer to their mothers than to their fathers, but also suggested that there was an important bond with their fathers. Thus, infrequent contact with the absent parent can be interpreted as being very stressful for these children. Despite the finding that there appeared to be a strong bond between the children and their parents, this degree of closeness did not appear to mitigate against the children developing behavioural and social adjustment difficulties, as has been suggested by researchers who believe that a good relationship with at least one parent has the effect of mitigating the negative factors of stress in a child's life. This finding was not surprising since the children from violent homes often suffer from inconsistent, understimulating or inappropriate

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attention from either or both parents (Ballack & Antell, cited in Steinmetz, 1977, p. 29).

The mothers of children in the treatment groups were asked if they thought their children had enjoyed their participation in the group. Eighteen point two percent of the mothers reported that their children enjoyed the group a little and 72.7% reported that their children have enjoyed the group a lot. This reponse was very consistent with the responses given by the children themselves.

Sixty-three point seven percent of the mothers with children in the treatment groups reported that they did not know what their children learned from the group. These mothers reported that their children did not talk about what they learned from the group with their parents. The children from the older treatment group were described as being more reluctant when it came to talking with their parents about the group experience.

Mothers were asked to comment on any changes in their child's behaviour since their child started the group. Twenty-seven point three percent of the mothers reported that their child's behaviour remained the same and 72.7% reported that their child's behaviour had improved since

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starting the group. No parent reported that their child's behaviour had worsened. The mothers were able to provide verbatim accounts of how their children's behaviour had improved. Among behaviour changes reported were: greater attachment to parents, more openness in communication, greater co-operation, greater control of their anger, greater sensitivity to others, greater capacity for understanding, calmer behaviour, improved knowledge about how to take care of themselves when confronted by a violent situation, and no longer getting involved in fights between parents. The mothers' reports indicated strong descriptive support for the primary hypothesis which suggested that children's behaviour and cognitive skills would show improvement following treatment.

5.3. SUMMARY AND CONCLUSIONS REACHED FROM THE CHILDREN'S PRE-GROUP INTERVIEWS

A great deal of demographic information was obtained from the children during their pre-group interview. The children's positive and negative perceptions of parental behaviour was assessed using a modified version of the Parent Perception Inventory. The children reported a more positive perception of their mothers' behaviour than their fathers'. However, the differences in the children's

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perceptions of their parents' behaviour were small. A mean of 12.5 was obtained for positive perceptions of mother's behaviour for all treatment children and a mean of 12.0 was obtained for perceptions of mothers' behaviour for all comparison children. The means for positive perceptions of father's behaviour was 8.6 for all treatment fathers and 11.4 for all comparison fathers. The mean values were also relatively low, suggesting that the children in this study perceived neither parent's behaviour in a particularly positive manner.

Mean values for children's negative perceptions of parental behaviour were also analyzed. The mean negative perception of mother's behaviour was 8.9 for all treatment children and mean negative perception of mother's behaviour was 9.1 for all comparison children. The mean negative perception of father's behaviour was 9.1 for all treatment children and the mean negative perception of father's behaviour was 7.0 for all comparison children. Again, there did not appear to be an appreciable difference between mother and father in the children's negative perceptions of their parent's behaviour. However, there was a slight tendency for all children to view their mother's and father's behaviour in a more positive light than a negative light.

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The results obtained from the parent perception inventory indicated that the children perceived their parents behaviour as having a fairly negative impact on them. Based on these results, it can be argued that the children in this study had little trust in their parents' ability to meet their needs. The low positive perception scores suggested that both mothers and fathers present themselves as being inattentive to the children's needs. These results have supported the findings of previous researchers who have found that in a violent family, both the batterer and the assaulted spouse have limited capacities to meet their children's needs.

Both treatment and comparison children revealed that they experienced a high level of fear during their pre-group interview. Wolfe's Fear Survey produced an overall mean of 50.8 for all treatment children and a mean of 49.4 for all comparison children. These results provided further evidence to support the work of researchers that contend that children from violent homes are subject to all kinds of anxiety disorders.

The children's stress as it related to negative life events experienced by the child was measured by using an

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adapted version of Johnson and McCutcheon Life Events Checklist. The mean for negative life events experienced by treatment children was 16.0 and the mean for negative life events experienced by comparison children was 23.2. The mean values for both treatment and comparison children were relatively high, suggesting that children from violent homes experience a high level of stress in their lives. The stress levels experienced by children from violent homes suggest another factor which may be operative in accounting for research findings which suggest that children from violent homes are at risk of developing behavioural maladjustments.

An adapted version of Procidano and Heller's Social Supports Scale was utilized to see if children from violent homes perceived their environments as a supportive one. A mean social support value of 6.1 was obtained for all treatment children and a mean social supports value of 8.0 was obtained for all comparison children. These values suggested that the children did not perceive their environment as a supportive one. The children did not feel that they could reach out to nuclear and extended family members or reach out to members in the community for help when confronted by a problem.

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Since the children in this study did not appear to perceive their environment as a supportive one, it was not surprising to find that the children did not talk with their friends about their parents fighting and/or separation. Sixty-one point nine percent of the children in this study indicated they did not talk with their friends about their parents' separation and 69.2% of all children indicated they did not talk with their friends about their parents' fighting.

Indeed, the children provided descriptive evidence that they view their families and community as a frightening place in which hitting and fighting is a normal way of life. One hundred percent of the children indicated that members of the same family hit each other some or a lot of the time, and 78.6% of the children stated that strangers hit each other some or a lot of the time.

However, despite the fact that the children appeared to view their world as an unfriendly place, this did not mean that they approved of hitting behaviour. One hundred percent of the children in this study indicated it was not OK for a man to hit a woman and 78.6% of the children indicated that it was not OK for a woman to hit a man. However, 57.2% of the children accepted the fact that it was

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OK for a parent to hit a child if the child misbehaved.

The pre-group interview administered to the children also generated descriptive data which suggested that the children in this study have already internalized violent behaviours to an extent. Eighty-two point one percent of the children indicated they get mad sometimes and 17.9% indicated they get mad often. Eighty-nine point three percent of the children stated they yell, scream or swear either some or a lot of the time. Seventy-five percent of the children stated that they fight, hit or punch other children their own age when they get mad. Seventy-eight point six percent of the children said they threaten other children their own age for teasing them and 53.6% indicated they strike out if another child teases them. Seventy-eight point six percent of the children reported hitting another child if they take something from them. However, only 33.3% of the children reported they hit back if another child hits them. This result suggested that if these children are hit, they adopt a victim role. Fifty-seven point one percent of the children stated they could recall incidents when their parents (either mother, father, or both) asked them for advise or help with a problem. Ninety-six point four percent of the children reported they help their mother when she is unhappy and 75.0% of the children reported that they

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help their father when he is unhappy. One hundred percent of the children indicated they worried about their mother and 78.6% reported they worried about their father.

These findings can be interpreted as a cause for concern, since they can all be taken as evidence that there is some role reversal and role confusion present in violent families. The children might be elevated to meet their parents' needs. Placing children in a parentified role is not only inappropriate, but encourages the children to take responsibility for their parents' behaviour. Thus, the burden of guilt experienced by children from violent homes is increased, resulting in greater confusion for the children in violent families and increases the risk of behavioural maladjustment for these children.

The children also showed a very stereotyped and traditional concept of male/female roles. This is in accordance with the literature which suggested that male/female roles are very rigid in violent homes.

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5.4. SUMMARY AND CONCLUSIONS REACHED FROM THE CHILDREN'S POST-GROUP INTERVIEWS

Ninety point nine percent of the children who participated in the treatment groups reported that they enjoyed the group a lot, while 9.1% or one child reported that he enjoyed the group a little. No child reported that they did not enjoy the group. These results were similar to the results obtained during the pilot group study held in August of 1985.

Further evidence that the children enjoyed their participation in the group came from the attendance figures at the group sessions. No child was absent from more than two sessions. These attendance figures can be interpreted as suggesting that both parents and children appeared to have made a concrete commitment to the group process. The group model utilized in the treatment groups appeared to have been successful in meeting the children's needs to the extent that the children attended groups regularly and found the experience to be meaningful for them. This observation was reinforced by the fact that 90.9% of the treatment children reported that they would like to repeat the group experience if they were given the opportunity to do so.

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The children were also asked to identify how much they had learned from the group. Ninety point nine percent of the treatment children indicated that they had learned a lot, while one child, 9.1%, reported that he had learned a little. These children were able to provide verbatim accounts of what they had learned. The children's responses reflected themes which were covered in weekly group sessions. The children stated that they learned about family violence, problem solving, it's OK to talk about feelings, mothers and fathers, separation and divorce, sexual abuse, as well as safety skills.

The treatment children were also asked to compare their group experience with other small group experiences in which they had participated. Only 54.6% of the treatment children reported that they had participated in a small group previously. This tends to support the literature which suggested that violent families and their offspring are socially isolated.

Eighty-three point three percent of the treatment children who reported that they had previous small group experiences, stated that their participation in the treatment group was a better experience than previous small group experiences. Sixteen point seven percent of these

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children reported that this experience was just about the same as their previous experiences.

Based on the findings reported by the mothers and their children, it can be argued that participating in the treatment group did have a positive impact on the emotional well-being, cognitive and behavioural skills of the children from violent homes. In addition, there was descriptive evidence to support the notion that treatment children showed improvements in social functioning within their family unit and that the treatment children's problem solving abilities and adaptive thinking processes had been enhanced.

It appeared that the co-therapists provided a warm, accepting environment which provided adequate amounts of emotional nourishment to the group participants, allowing these children to confront their feelings in a helpful way. This enabled the children to reach out to each other and engage in a self help process as well as a learning and growth process. The developmental group model utilized in this research appeared to have recognized the developmental needs of the children as well as recognize the developmental process involved in the social work practice with groups. This probably contributed greatly to the children's

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perception that they enjoyed the process, despite the painful matters that were dealt with.

5.5. SUMMARY AND CONCLUSIONS REACHED BY TESTING THE PRIMARY HYPOTHESIS

The Achenbach Child Behaviour Checklist was utilized in this research as a broad measure of child adjustment. This behaviour checklist provided this researcher with scores measuring a child's total behaviour problems and a score measuring social competency. Improvement in total behaviour scores were interpreted as an improvement in child adjustment and improved child conduct.

Pre-test scores obtained for all children showed that both treatment and comparison children scored very high on total behaviour problems and very low on social competency. Scores for both measures were within the clinical range. Post-test scores for total behaviour problems revealed a marked improvement, with both treatment and comparison children obtaining scores just within normal limits. Paired comparison t-tests revealed no statistical significance due to main effect for intervention, however, did reveal statistical significance for main effect of occasions.

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It was concluded that reduction in the overall level of behavioural problems experienced by all children was primarily the result of lower levels of marital violence. Although statistical significance due to treatment was not achieved, an inspection of scores for all treatment children showed a marked shift in a positive direction which suggested that treatment does have some positive impact. The mean scores obtained for total behaviour problems and social competency in the pre-test situation supported the findings of previous researchers who found that children from violent homes are at risk for child maladjustments, both behaviourally and socially.

One hundred percent of the mothers with children in the treatment groups reported that their child's conduct had improved either a little or a lot, following treatment. The mothers were able to provide verbatim accounts of how their child's conduct had improved. The mothers' reports on improvements in child conduct were in correspondence with the prediction of improvements in child conduct hypothesized by the primary hypothesis. Thus, a significant chi-square value was obtained for this inquiry in the post-test situation. The mothers' report provided strong evidence to suggest that group work with children from violent homes was effective in improving child's conduct, thus supporting the

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primary hypothesis.

Three categories of inquiries in the child's interview schedule measured the child's cognitive abilities and behavioural skills. A significant interaction due to treatment (test for main effect of interaction) was obtained for the category of responses which dealt with parental conflict. No significant interaction due to treatment was found for the categories which dealt with peer conflict and the category which dealt with circumstances when hitting behaviour was acceptable or when it was not acceptable.

The fact that significance at the .005 level of probability was obtained due to treatment for the category dealing with parental conflict provided support for the primary hypothesis which predicted that treatment children would show improved cognitive and behavioural skills in the post-test situation.

The fact that statistical significance due to treatment was not obtained for the category of responses that dealt with peer conflict was not surprising since the focus of the treatment group was aimed at helping children develop better coping strategies with situations involving parental conflict and the the treatment program was not geared

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towards improved peer relationships.

The fact that statistical significance due to treatment was not obtained from the category of responses dealing with hitting behaviour suggested that the children's perceptions of when hitting was acceptable or not had not changed due to group treatment. It was conjectured that perhaps this category of responses did not measure an improvement in cognitive abilities and behavioural skills, but rather measured the children's perceptions and attitudes about situations involving hitting behaviour. This researcher also felt that changing attitudes and perceptions would take more intensive work with children from violent families, since attitudes and perceptions are deeply ingrained and thus much more resistant to change.

This researcher believed that the non-significant findings also could be interpreted in other ways. First, it was possible that since post-testing of the children took place shortly after completion of the treatment groups, the children did not have enough time to integrate their new learning and improved problem solving abilities. If this were the case, then it can be argued that post testing should be conducted perhaps six months after completion of the treatment groups, so that adequate integration of new

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learning and improved coping strategies can take place. If post-testing took place six months after completion of the group, the Achenbach Behaviour Checklist could be utilized as a measure without infringing on the reliability of this instrument. Secondly, if the suggestion that the category of responses dealing with hitting behaviour measured the children's perception and attitudes toward hitting behaviour, rather than improvements in cognitive abilities and behavioural skills, then this might also be the case for the categories which dealt with parental conflict and peer conflict. If this indeed was the case, then the criteria to measure cognitive abilities and behavioural skills would need further refinement. Thus, based on findings generated in testing the primary hypothesis, it appeared that the criteria used to make measurements had good face validity, but poor construct validity. Unfortunately, the difficulties with construct validity were not discovered during the preliminary testing of the children's interview schedule when the pilot study took place in Guelph, Ontario during the summer of 1985.

This study produced some significant results indicating support for the primary hypothesis, although significance was not achieved for all measures. Results obtained in testing the primary hypothesis warrant only tentative

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interpretation. Based on the results generated, one can not make any cause-effect statements regarding the effectiveness of social work practice with groups for children from violent homes. However, it did appear that children did make some measureable gains and this suggests that this treatment modality has a positive impact on children from violent homes and is meeting some of the needs of these children.

5.6. SUMMARY AND CONCLUSIONS REACHED BY TESTING THE SUB-HYPOTHESES

Wolfe's fear survey was utilized in this research to measure the overall level of fear experienced by children before and following group treatment. No significant main effect for interaction was found although there was a significant main effect for occasions at the .001 level of probability. Children from both treatment and comparison groups received high fear scores in the pre-group situations. However, both treatment and comparisons showed a marked decline in the overall level of fear in the post-test situation. It was concluded that the reduction in level of fear was likely related to a lessening of violence in the family settings of the children who participated in this research, rather than being affected by participation

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in the group.

It was believed by this researcher that participation in the treatment group would have produced a "cathartic affect" and thus reduce the children's negative perception of stressful life events. Also, it was reasoned that if the treatment group was successful in providing the children with more coping strategies, this would act in such a way as to reduce the child's negative perceptions of stressful life events. No significant main effect for interaction was found for either the younger or older children groups, however, where the results were combined for all children to control for possible "size-effect" error, there was a significant interaction due to treatment at the .05 level of probability. However, significance was in the opposite direction to what was expected. Children in the treatment groups scored higher in their negative perceptions of stressful life events following treatment, while comparison children showed virtually no change in their negative perceptions of stressful life events between pre-group and post-group testing. Therefore, the alternative sub-hypotheses were rejected, and the null sub-hypotheses regarding the children's negative perceptions of stressful life events were accepted.

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It appeared that the effect of group treatment was to increase the children's awareness of negative life events to which they had been exposed. It appeared that children in the treatment groups started to think about the stressful situations to which they had been exposed and perhaps the children were able to view their stressful life events in a more realistic perspective. Thus, there was a greater awareness that as children from violent homes, they were frequently confronting stressful situations. After analyzing the data, it was believed by this researcher that the increased awareness of the negative stressful life events confronted by the children from violent homes will likely have a positive impact on these children, since in order to be able to utilize the appropriate strategies to deal with stressful situations, one needs to be aware of situations that create negative stressful events in one's life.

No significant interaction due to treatment was found in the measure which evaluated the children's perceptions of sexual roles for either the younger, older, or all children that participated in this study. It was expected to find that treatment children would show a less stereotyped and less rigid view of male/female roles following treatment. The results showed that social work practice with groups was

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not successful in altering the children's perception of male/female roles. It was important to note that both children in treatment and comparison groups viewed male/female roles in a very stereotyped and traditional manner during pre-group and post-group testing. Upon reflection, this result was perhaps not surprising at all. Since the items dealing with sexual roles and sexual stereotyping were designed to measure the children's perceptions and attitudes towards sexual stereotyping, and since it is known that perceptions and attitudes are very resistant to change, perhaps it was too much to expect that perceptions and attitudes toward sexual roles could be changed in a treatment group which met only for one and half hours for a ten week period of time. Thus, the null sub-hypotheses were accepted.

A shortened version of Procidano and Heller's Social Support Scale was utilized in this project. It was predicted that both younger and older children in the treatment groups would be able to utilize social supports to a greater extent than the comparison groups, following treatment. No significant main effect for interaction was found among any of the groups. The results suggested that at the time of post-testing, the children in the treatment groups were not utilizing the social supports in both their

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family and/or in community. However, notable exceptions were also reported on. It was concluded that at the time of post-testing, treatment children still did not have the opportunity to utilize their social supports and as a result, the children were not able to report on greater rate of utilization of social supports. Also, it was found that family factors might mitigate against utilizing social supports. If there had been an adequate incubation period following the ending of the treatment groups, there would likely be a greater likelihood of measuring change in the utilization of social supports. Also, it might be against unspoken family rules for these children to reach out to others and this norm might be quite resistant to change.

Another factor that needs to be considered when interpreting the results obtained in testing the various hypotheses is that other factors such as the frequency and intensity of violence in the home during the course of the treatment groups might have confounded any of the results generated by this research project. There was no method to control for such factors. Attempts were made to control for intervening variables which were within the control of this researcher.

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5.6. SUMMARY

This research has shown that the difficulties faced by children from violent homes is not uni-dimensional, but complex, in which a multitude of factors play a part. Children from violent families have faced and continue to face not only the negative impacts of familial violence, but also the impacts of associated stressors which are present in violent families.

This research has documented the necessity of intervening with children from violent homes, not only to minimize the negative effects of intra-spousal violence, but also to break into the cycle of intergenerational violence. The data generated by this study has suggested that social work with groups can be an effective means to provide support to children from violent homes, and also exists as a means of breaking into and stopping the intergenerational transmission of intra-spousal abuse. This study now concludes with recommendations to help achieve the prevention of intra-spousal abuse by intervening with the children from violent homes.

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5.7. RECOMMENDATIONS

1. Research into the impact of intra-spousal violence on children is only in its infancy. Further exploratory research is needed into the multi-dimensional factors that impact on children from violent homes. For example, the impact of the child witnessing wife battering may partially be a function of a mother's degree of impairment, as well as the concomitant disruption and uncertainty the child faces. Both long term and short term effects of exposure to family violence need to be studied.

2. In order to help our understanding of the long range effects of family violence on children and to help measure the impact of treatment and preventive strategies, longitudinal research into this area is required.

3. Research on the effects of children's exposure to wife battering is faced with a number of challenges. Improved instruments to measure the frequency and intensity of violence, instruments to measure the multi-dimensional function impacting on children from violent homes, and instruments to measure the effectiveness of treatment modalities are needed and await further development.

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4. There is a need to consolidate and evaluate the information from existing and/or completed projects looking at the impact of family violence on children. This information should be used to develop a comprehensive information system containing readily accessible data into the effects of family violence on children.

5. At the present time, there are no definitive answers or treatment models to help children from violent homes, cr on the best methods of intervention with these children. There is a need for further demonstration projects, research, policy development and appropriate funding for preventive strategies by government agencies and social agencies which have the resources to accomplish the task.

6. There is a need to develop a conceptual model to help provide a better understanding of the effects of family violence on children. Such a conceptualization would encompass a variety of psychological, social, and structural elements - factors that may be considered as being operative simultaneously in the lives of these children. Based on the results obtained in this study, this researcher believes it would be a mistake to approach the investigation of this phenomenon from only one perspective such as concentrating on the psychopathologies present in children from violent

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homes, while ignoring the relevance of social and family factors.

7. If the present research were to be replicated, it is recommended that further refinement be made to the instruments used to measure changes resulting from the impact of treatment; to insure greater construct validity, and that a period of time, such as six months, be allowed to lapse before post-testing is completed. This would allow for an adequate period of incubation to permit for the children's integration of newly learned coping strategies into their actual behaviour. It is also recommended that more children be utilized in the research to fulfill the sampling requirements of empirical research.

8. The results obtained in the present research suggests support for the concept that social work practice with groups may be an effective strategy to build on the child's cognitive and behavioural responses to family violence. It is recommended that other researchers and helping professionals study the results of this demonstration project with the aim to stimulate their own thoughts and encourage them to develop their own treatment programs for children from violent homes.

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9. Consideration should be given to the provision of government funding to allow for the provision of more counselling services to children who have been exposed to parental violence.

10. The government agencies need to recognize that preventing long term adjustment difficulties in children from violent homes and stopping intra-spousal violence will require finding additional resources than just counselling services for these children. There is also a need for developing or maintaining a critical support system for all family members, assistance for both parents in managing family crisis and avoiding physical violence, and opportunities for all family members to learn problem solving strategies, as well as developing advocacy services to the victims of family violence. Traditionally, services for battered women and their children have been the outgrowth of the women's movement, in particular, the members of the women's movement involved in the development of transition houses for the abused woman and her children. There must be a recognition that it is unfair to expect transition houses to carry the burdens all alone.

11. Municipalities should undertake the formation of co-ordinating committees on family violence with members from

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the criminal justice, medical, helping professions, and social service systems. The committees should discuss ways of preventing family violence and develop an integrated community response to the problem. The aims should include raising the community's awareness of the impact of intra-spousal violence in the community, the batterer, the abused partner, and the children from violent homes, as well as the provision of immediate and preventive strategies to break into the intergenerational transmission of family violence, the focus being, to bring a stop to family violence.

12. Appropriate levels of government need to develop ongoing mechanisms for the distribution of police education kits, primary materials, and other pertinent information regarding the impact of intra-spousal violence on children, to be used by community agencies working at developing community services for families and children from violent homes. There is a need to educate the public about the social and familial disruptions created by family violence.

13. Government agencies and professional associations should endeavour to provide educational and learning opportunities to helping professionals, and other professionals who come into regular contact with children, about the special needs of children from violent homes, so

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that these professionals can recognize and respond appropriately to the needs of children from violent homes.

14. Educational officials should encourage local school boards to develop and implement appropriate courses of study and support materials concerning family relationships and the impact of violence on the family and their children. Related in-service training for school staff is alsc encouraged. This should occur in both elementary and secondary school curriculum.

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APPENDIX A

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Session 1: Introduction to the Group Experience

Purpose

To provide the participants with an opportunity to become acquainted with:

a) the group leaders
b) the group members, and
c) the theme of the 10 group sessions.

Objectives

1. To provide a nonthreatening environment for the children.
2. To explain the purpose of the group.
3. To discuss the mutuality of the children's experiences.
4. To discuss the issue of confidentiality.
5. To formulate the group's rules.

Agenda

1. Introduction to group members
2. Purpose of the group program
3. Rule setting
4. Activity: Human Scavenger Hunt
5. Snack time

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Session 2: Labelling Feelings

Purpose

To provide group members with a forum to discuss emotions which they may experience as a result of being a member of a violent family.

Objectives

1. To continue the process of cohesion building.
2. To give children the tools that they need to identify and express their feelings.
3. To begin the process of problem-solving.

Agenda

1. Unfinished business
2. Label the 4 feeling groups
3. Collage making
4. Snack time

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Session 3: Dealing with Anger

Purpose

To assist the children in breaking down into its' component parts, feelings that the children present as anger.

Objectives

1. To help the children to understand what are the healthy/unhealthy ways of dealing with anger.
2. To provide the children with suggestions on how they can cope more effectively with anger.

Agenda

1. Unfinished business
2. Discuss with the children situations that cause them to get angry
3. The children are instructed in how to implement constructive coping skills. This is facilitated by role playing conflict scenarios. (See scenarios).

   Stages:

   a) Identify the problem

   b) Get in touch with your real feelings and then accept them

   c) Step back

   d) Take action

   e) Protect yourself
4. Snack time

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Conflict Scenario 1

Girls and boys are riding home from school on the bus. A bully named Wayne, grabs Paul's mittens and starts tossing them around the bus. After asking for them back and grabbing as they flew past his head, Paul managed to get only one mitten back. The bus arrives at Paul's stop and he must get off with only one mitten. This is also the bully Wayne's stop. After the two boys get off the bus, Paul goes over and punches Wayne in the eye.

Conflict Scenario 2

Jane and Randy are in grades 8 and 9 respectively. They have been going out for two months. Each goes to a different school. One day Jane walks by Randy's school and sees him holding hands with Rhonda. Jane is both hurt and angry. The next day Jane is with her friends when she sees Rhonda across the street. Encouraged by her friends, Jane confronts Rhonda, slapping her across the face.

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Session 4: Responsibility for Violence/Parents

Purpose

To assist the group members in acknowledging the violence in their families. The number one priority is to help the children in reducing their feelings of self-blame and to ensure that they take action to promote their safety.

Objectives

1. To provide members with accurate information about violence.
2. To help the children to understand who is responsible for the violence in the family and for their parents' behavior.
3. To provide the children with strategies that they can use when their parents are fighting.

Agenda

1. Unfinished business
2. Artwork: Family Representation
3. Education on Family Violence
4. Snack time

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Session 5: Responsibility for Violence/Parents

Purpose

Same as previous meeting

Objectives

Same as previous meeting.

Agenda

1. Unfinished business
2. Role playing
3. Snack time

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Session 6: Safety Skills, Child Abuse, Sexual Abuse

Purpose

To educate group members on how to stay safe in potentially dangerous situations. Sexual abuse is discussed within this context and members learn the importance of telling someone they trust should this type of event occur.

Objectives

1. To clarify topic area.
2. To discuss with the children what they are/not responsible for with respect to:
   a) Mom and dad fighting
   b) Peer relationships
   c) Sexual abuse
3. To assist children in developing a safety plan
4. To delineate social supports available for children

Agenda

1. Unfinished business
2. Members are asked to define abuse and the different types
3. Members are informed that in situations that are dangerous they have a right to safety
4. The developing of safety plans
5. Snack time

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Session 7: Social Competence and Self-Concept

Purpose

To assist the children in developing a positive sense of self and the unique qualities which they possess.

Objectives

1. To emphasize the positive aspects of each child.
2. To help the children to explore how other people see them and how they see themselves.

Agenda

1. Unfinished business
2. Human figure life puzzle
3. The ungame
4. Snack time

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Session 8: Sexual Stereotyping and the Media

Purpose

To facilitate a better understanding among group members regarding the myths of sexual stereotyping.

Objectives

1. To help children to develop flexible sex-roles.

Agenda

1. Unfinished business
2. Introduce topic via discussion on:
    a) Career choices
    b) Fairy tales
    c) Rock music
    d) Prime television
3. Snack time

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Session 9: Wishes About The Family

Purpose

To provide participants with an opportunity to discuss their familiy situations in an nonthreatening environment.

Objectives

1. To explore the dynamics of the children's families.

Agenda

1. Unfinished business
2. Children are asked to list the various types of families that exist in society
3. Narrow discussion to focus on child's own life experiences
4. Open discussion
5. Snack time/Preparation for group termination

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Session 10: Group Termination

Purpose

To provide the children with an opportunity to effect a positive termination.

Objectives

1. To review what was learned throughout the group program.
2. To evaluate the positive and negative aspects of the group process.
3. To effect termination with fellow group members.

Agenda

1. Unfinished business
2. Review the preceding group sessions
3. Verbal gifts
4. Termination party

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APPENDIX B

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GROUP MODEL

The Children of Violence Group Program was based on the "Boston Model" of group development. The central theme underlying the group process is emotional closeness.

Preparation

- acquire group theory
- determine group purpose and fit with agency mandate
- select group setting
- choose group composition
- interview prospective candidates
- contract with group members

Stages of Group Development

Stage One: Pre-affiliation

Themes

- ambivalence about belonging to the group
- search for structure
- concern about group boundaries, purpose, etc.

Interactions

- guarded interaction to avoid closeness
- integrity of ego is preserved and protected from injury of new situations
- need to maintain inner control
- promise of gratification/past group experiences
- dependency on therapist
- sizing each other up, seeking approval, acceptance
- uncertainty, anxiety, self-consciousness, non-committal behavior
- cohesiveness is weak, little common basis for members' attraction to the group

Worker Tasks

- to allow/support distance while inviting trust
- to provide activity, leadership, structure
- to communicate purpose/goals of the group
- to define group boundaries i.e., membership, confidentiality
- identify common ground of members
- to support each member's entry into the group

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Stage Two: Power and Control

Themes
- -roles begin to appear
- -patterns of communication are identifiable
- -alliances and subgroups form
- -questions/concerns about membership

Interactions
- -social/emotional task is to establish places in interaction
- -power required for self-protection and for control over amount of gratification to be taken from group experience
- -worker major source of gratification
- -worker ascribed power to influence the affairs of the group.

Worker Tasks
- -to protect safety of individuals and property
- -to permit but control rebellion in the service of clarifying the power struggle
- -to provide activity for mastery
- -to preserve autonomy of individuals moving toward major committment to involvement in the group

Stage Three: Intimacy or Affiliation

Themes
- -feelings are expressed more freely
- -family like sibling rivalry with worker as parent
- -group seen as a place where growth and change occur

Interactions
- -members can focus on individual attitudes and emotions
- -vascillation in ability to carry through on plans

Worker Tasks
- -continued, consistent giving to group to avoid feelings of desertion
- -worker takes responsibility or gives responsibility as group vascillates in ablity to carry out work.
- -clarifies positive and negative feelings

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Stage Four: Differentiation

Themes

-clarification of power relationships provides base for autonomy and intimacy
-clarification of intimacy permits acceptance of personal needs which underlie ability to differentiate and evaluate relationships and events in group on a reality basis

Interactions

-recognition of individual needs and rights
-mutual identification and high communication
-shared leadership/functional roles
-experimentation with alternative or new modes of behavior
-power problems are minimal
-decision making and control efforts are carried out on a less emotional basis
-cohesion
-the group experience achieves a functionally autonomous character creating its' own frame of reference

Worker Tasks

-helping/encouraging the group to run itself
-seeking evaluation/feedback from members about group activities, feelings and behavior

Stage Five: Termination/Separation

Themes

-purpose of group has been achieved
-members move apart to find new resources for meeting social/ emotional needs

Interactions

-possible regression of members
-recapitulation of earlier group experiences
-denial/flight/evaluation

Worker Tasks

-to let go
-to facilitate evaluation/expression of group experience
-feedback of progress

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APPENDIX C

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The Lester B. Pearson Centre, the Women's Centre, and Dr. Peter Jaffe from the London Family Court Clinic are organizing a 'group counselling program' for children (aged 7 - 10, and 11 - 13) who have been exposed to serious family conflicts (such as marital violence).

Our previous work with children from violent homes has found that while some show overt signs (e.g. aggression, depression) of their exposure to family violence, other children display less obvious adjustment difficulties (e.g. inappropriate attitudes about violence, poor problem solving skills). Both types of children can benefit from a group program specifically designed to meet their needs.

The counselling program will consist of 10 group sessions each lasting approximately 1½ hours. The sessions will involve education and group discussion about family conflict, learning to express feelings and thoughts about conflicts , discussion of how to solve problems with family and friends, and improving self-esteem. Group activities and refreshments will be provided to help maintain the interest of younger children. In order to determine how valuable this group was for the children, the parent(s) and child will be asked to complete a questionnaire before and after the group is completed. The parent(s) will receive some individual feedback about their child after the group is completed.

If you know of any children who have witnessed family violence and think that they may benefit from participation in the group, please call Mr. Peter Dirks at or The groups will be held on Saturdays from October 5 until December 7. Initial intake interviews for the groups will be held during the month of September.

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APPENDIX D

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INFORMATION AND PERMISSION FORM

The Lester B. Pearson Centre, the Women's Center, and Dr. Peter Jaffe from the London Family Court Clinic are organizing a 'group counselling program' for children (aged 7 - 10, and 11 - 13) who have been exposed to serious family conflicts (such as marital violence).

The counselling program will consist of 10 group sessions each lasting approximately 1½ hours. The sessions will involve education and group discussion about family conflict, learning to express feelings and thoughts about conflicts, discussion of how to solve problems with family and friends, and improving self - esteem. Group activities and refreshments will be provided to help maintain the interest of younger children. In order to determine how valuable this group was for the children, the parent(s) and child will be asked to complete a questionnaire before and after the group is completed. The parent(s) will receive some individual feedback about their child after the group is completed.

In order to determine how valuable this group was for the children, you and your child will be asked to fill out a questionnaire before and after the group is completed. Some of the sessions may be videotaped or observed for future leader training purposes.

Your participation is completely voluntary, and you are free to withdraw from the study at any time. All information abtained will remain confidential subject to provisions of the Child's Welfare Act, which requires everyone to report to the Children's Aid Society any case in which the child is in need of protection. All identifying information will be destroyed once the data have been gathered. If you have any questions, please feel free to ask.

I give my permission for my child(ren) to participate in this program.

____________________ (Name) ____________________ (Signature)

____________________ (Name(s) of Child(ren))

____________________ (Witness) ____________________ (Date)

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APPENDIX E

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Ontario

Mental Health Act

or Examination of a Clinical Record

I, ______________________________
(print full name of person)

of ______________________________
(address)

hereby consent to the disclosure or transmittal to or the examination by

____
(print name)

of the clinical record compiled in ______________________________
(name of psychiatric facility)

in respect of ______________________________
(name of patient)

See Note 5.

____
(signature)

____
(witness)

Dated the ____________ day of ______________________ 19 ______

Notes:

1. Consent to the disclosure, transmittal or examination of a clinical record may be given by the patient or (where the patient has not attained the age of majority or is not mentally competent) by the nearest relative of the patient.
   See subsection 29(3) of the Act.

2. Patient.
   Clause 29(1)(*b*) of the Act states that "'patient' includes former patient, out-patient and former out-patient".

3. Mentally competent.
   Clause 1(*h*) of the Act defines "mentally competent" as "having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent".

4. Nearest relative.
   Clause 1(*j*) of the Act is as follows:
   "'nearest relative' means,
   (i) The spouse who is of any age and mentally competent, or
   (ii) if none or if the spouse is not available, any one of the children who has attained the age of majority and is mentally competent, or
   (iii) if none or if none is available, either of the parents who is mentally competent or the guardian, or
   (iv) if none or if neither is available, any one of the brothers or sisters who has attained the age of majority and is mentally competent, or
   (v) if none or if none is available, any other of the next of kin who has attained the age of majority and is mentally competent".

5. *Signature.*
   Where the consent is signed by the nearest relative, the relationship to the patient must be set out below the signature of the nearest relative.

O. Reg. 609/90, s. 16 (14)

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APPENDIX F

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PRE - GROUP INTERVIEW WITH MOM

Interviewer: ______________________ Date: __________________________

Location: _________________________

1. Mother's full name: ____

2. Names of all children living with mother:

   (a) ______________________________ Sex __________ Age ______

   (b) ______________________________ Sex __________ Age ______

   (c) ______________________________ Sex __________ Age ______

   (d) ______________________________ Sex __________ Age ______

   (e) ______________________________ Sex __________ Age ______

3. Estimated family income per year. Present $ ______________

   Recent (if different) $ ______________

4. Mother's highest level of education completed: ____________

   ____

5. Number of times the family has changed residence since the

   birth of the eldest child ________________.

6. Number of school changes ________________.

7. Has anyone in your family ever sought help for family or personal problems?

Person	Type of counselling (i.e. group, couple, individual)	# Sessions	Approx. date of involvement

8. Length of current marriage/commonlaw relationship: ____________

9. Frequency of separations in the past two years: ______________

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10. Duration of most recent separation (where either mother and child, or father, left home) ____________________

11. Duration of previous separations: ____________________

12. Number of significant male models that the child has had at home (i.e. number of male partners of mother) __________

13. Number of violent male models: __________

14. How close is child to:

Mom:	1	2	3	4	5	6	7	Dad:	1	2	3	4	5	6	7
	not close						very close		not close						very close

15. If parents are separated, how often does the child(ren) see their father (or mother's most recent partner): __________

daily ______________

weekly ______________

monthly ______________

other (specify) ________

has no contact ________

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CONFLICT TACTICS SCALE
M.A. Straus

Instructions: No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that you and your husband might have done when you had a dispute and would first like you to tell me for each one how often you did it in the past year.

	Female to Male								Male to Female							
	NEVER	ONCE	TWICE	3-5 TIMES	6-10 TIMES	11-20 TIMES	MORE THAN 20	DON'T KNOW	NEVER	ONCE	TWICE	3-5 TIMES	6-10 TIMES	11-20 TIMES	MORE THAN 20	DON'T KNOW
a) discussed the issue calmly	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
b) got information to back up (your/his) side of things	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
c) brought in or tried to bring in someone from outside to help	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
d) insulted or swore at the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
e) sulked and/or refused to talk about it	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
f) stomped out of the room or house	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
g) cried	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
h) did or said something to spite the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
i) threatened to hit or throw something at the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
j) threw or smashed or hit or kicked something	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
k) threw something at the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
l) pushed, grabbed, or shoved the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
m) slapped the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
n) kicked, bit, or hit with a fist	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
o) hit or tried to hit with something	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
p) beat up the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
q) threatened with a knife or gun	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
r) used a knife or a gun	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7

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CONFLICT TACTICS SCALE
M.A. Straus

Instructions: No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that you and your husband might have done when you had a dispute and would first like you to tell me for each one how often you did it in the past year.

	Female to Male								Male to Female							
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a) discussed the issue calmly	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
b) got information to back up (your/his) side of things	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
c) brought in or tried to bring in someone from outside to help	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
d) insulted or swore at the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
e) sulked and/or refused to talk about it.	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
f) stomped out of the room or house	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
g) cried	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
h) did or said something to spite the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
i) threatened to hit or throw something at the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
j) threw or smashed or hit or kicked something	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
k) threw something at the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
l) pushed, grabbed, or shoved the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
m) slapped the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
n) kicked, bit, or hit with a fist	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
o) hit or tried to hit with something	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
p) beat up the other one	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
q) threatened with a knife or gun	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7
r) used a knife or a gun	0	1	2	3	4	5	6	7	0	1	2	3	4	5	6	7

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CHILD BEHAVIOR CHECKLIST FOR AGES 4-16

For office use only
ID #

CHILD'S NAME (1-5) (6,7:01)

SEX ☐ Boy 1 ☐ Girl 2 (8) | AGE (9-10)

TODAY'S DATE Mo. ____ Day ____ Yr. ____ | CHILD'S BIRTHDATE Mo. ____ Day ____ Yr. ____

GRADE IN SCHOOL (11-16:BLANK)

THIS FORM FILLED OUT BY:
☐ Mother
☐ Father
☐ Other (Specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating skate boarding, bike riding, fishing, etc.
☐ None

(17: 0-3)

	Compared to other children of the same age, about how much time does he/she spend in each?					Compared to other children of the same age, how well does he/she do each one?				
	Don't Know 9	Less Than Average 1	Average 2	More Than Average 3		Don't Know 9	Below Average 1	Average 2	Above Average 3	
a. ____	☐	☐	☐	☐	(18)	☐	☐	☐	☐	(21)
b. ____	☐	☐	☐	☐	(19)	☐	☐	☐	☐	(22)
c. ____	☐	☐	☐	☐	(20)	☐	☐	☐	☐	(23)

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.)
☐ None

(24: 0-3)

	Compared to other children of the same age, about how much time does he/she spend in each?					Compared to other children of the same age, how well does he/she do each one?				
	Don't Know 9	Less Than Average 1	Average 2	More Than Average 3		Don't Know 9	Below Average 1	Average 2	Above Average 3	
a. ____	☐	☐	☐	☐	(25)	☐	☐	☐	☐	(28)
b. ____	☐	☐	☐	☐	(26)	☐	☐	☐	☐	(29)
c. ____	☐	☐	☐	☐	(27)	☐	☐	☐	☐	(30)

III. Please list any organizations, clubs, teams, or groups your child belongs to.
☐ None

(31: 0-3)

	Compared to other children of the same age, how active is he/she in each?				
	Don't Know 9	Less Active 1	Average 2	More Active 3	
a. ____	☐	☐	☐	☐	(32)
b. ____	☐	☐	☐	☐	(33)
c. ____	☐	☐	☐	☐	(34)

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc.
☐ None

(35: 0-3)

	Compared to other children of the same age, how well does he/she carry them out?				
	Don't Know 9	Below Average 1	Average 2	Above Average 3	
a. ____	☐	☐	☐	☐	(36)
b. ____	☐	☐	☐	☐	(37)
c. ____	☐	☐	☐	☐	(38)

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3-81 Edition

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V. 1. About how many close friends does your child have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more (39)

(40-41:BLANK)

2. About how many times a week does your child do things with them? 1 ☐ less than 1 2 ☐ 1 or 2 3 ☐ 3 or more (42)

VI. Compared to other children of his/her age, how well does your child:

	Worse 1	About the same 2	Better 3	
a. Get along with his/her brothers & sisters?	☐	☐	☐	(43)
b. Get along with other children?	☐	☐	☐	(44)
c. Behave with his/her parents?	☐	☐	☐	(45)
d. Play and work by himself/herself?	☐	☐	☐	(46)

VII. 1. Current school performance—for children aged 6 and older:

☐ Does not go to school

	Failing 1	Below average 2	Average 3	Above average 4	
a. Reading or English	☐	☐	☐	☐	(47)
b. Writing	☐	☐	☐	☐	(48)
c. Arithmetic or Math	☐	☐	☐	☐	(49)
d. Spelling	☐	☐	☐	☐	(50)
Other academic subjects—for example: history, science, foreign language, geography. e. ______	☐	☐	☐	☐	(51)
f. ______	☐	☐	☐	☐	(52)

2. Is your child in a special class?

2 ☐ No 1 ☐ Yes—what kind? (53)

3. Has your child ever repeated a grade?

2 ☐ No 1 ☐ Yes—grade and reason (54)

4. Has your child had any academic or other problems in school?

2 ☐ No 1 ☐ Yes—please describe (55)

When did these problems start?

Have these problems ended?

☐ No ☐ Yes—when?

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VIII. Below is a list of items that describe children. For each item that describes your child *now* or *within the past 6 months*, please circle the *2* if the item is *very true* or *often true* of your child. Circle the *1* if the item is *somewhat* or *sometimes true* of your child. If the item is *not true* of your child, circle the *0*.

0 1 2 1. Acts too young for his/her age 16
0 1 2 2. Allergy (describe): ____________
____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex 20
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): ____________
____
0 1 2 10. Can't sit still, restless, or hyperactive 25
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals 30
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things 35
0 1 2 21. Destroys things belonging to his/her family or other children
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other children 40
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food (describe): ____________
____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): ____________
____
0 1 2 30. Fears going to school 45

0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior 50
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with children who get in trouble
0 1 2 40. Hears things that aren't there (describe): ____________
____________ 55
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Likes to be alone
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense 60
0 1 2 46. Nervous movements or twitching (describe): ____________
____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other children
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious 65
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight 70

56. Physical problems without known medical cause:

0 1 2 a. Aches or pains
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe): ____________
0 1 2 e. Rashes or other skin problems 75
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): ____________
____

Please see other side

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0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): ______

______ 80

0 1 2 59. Plays with own sex parts in public 16
0 1 2 60. Plays with own sex parts too much

0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy

0 1 2 63. Prefers playing with older children 20
0 1 2 64. Prefers playing with younger children

0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): ______

______

0 1 2 67. Runs away from home
0 1 2 68. Screams a lot 25

0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):

______

______

0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires

0 1 2 73. Sexual problems (describe):

______

______ 30

0 1 2 74. Showing off or clowning

0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most children

0 1 2 77. Sleeps more than most children during day and/or night (describe): ______

______

0 1 2 78. Smears or plays with bowel movements 35

0 1 2 79. Speech problem (describe): ______

______

0 1 2 80. Stares blankly

0 1 2 81. Steals at home
0 1 2 82. Steals outside the home

0 1 2 83. Stores up things he/she doesn't need (describe):

______ 40

0 1 2 84. Strange behavior (describe): ______

______

0 1 2 85. Strange ideas (describe):

______

0 1 2 86. Stubborn, sullen, or irritable

0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot 45

0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language

0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe):

______

0 1 2 93. Talks too much 50
0 1 2 94. Teases a lot

0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much

0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking 55

0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe):

______

0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy

0 1 2 103. Unhappy, sad, or depressed 60
0 1 2 104. Unusually loud

0 1 2 105. Uses alcohol or drugs (describe):

______

0 1 2 106. Vandalism

0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed 65

0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex

0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worrying

113. Please write in any problems your child has that were not listed above:

0 1 2 ______ 70

0 1 2 ______

0 1 2 ______

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

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APPENDIX G

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CHILD INTERVIEW PRE GROUP

Child's Name:____________________ Date:____________________

Interviewer:____________________ Location:________________

SOCIAL COMPETENCE

What are some of your favorite activities/hobbies/sports?

How good do you think you are at these activities, compared to other kids your age?

Are you involved in any clubs or teams (ie. brownies, scouts)?

a) If yes, how many? (name them)

How much do you enjoy participating in them?

Not at all Somewhat A lot

b) If no, would you like to be?

If yes, what could make that possible?

Do you have any close friends that you like to spend time with? How many?

What kinds of things do you like to do with them?

How often do you play with them per week?

< 1 day per week _____

1 or 2 days per week _____

3 or more days per week _____

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Do you usually play with them at your house or go somewhere else?

Do you think your mom likes your friends?

Do you think your dad likes your friends?

What are some of your favorite subjects at school?

What are some of your least favorite subjects at school?

Do you have any problems in school? Describe.

Do you have problems with:

a) schoolwork _____

b) teacher _____

c) peers _____

d) other (specify) _____

When you have problems at school, do you ever ask your teacher or another student for help? (If no, why not)

Can you tell me about something really good that's happened to you in the past year?

Can you tell me about something really bad that's happened to you in the past year?

SEXUAL STEREOTYPING

How are boys different from girls?

How are girls different from boys?

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What would you like to be when you grow up?

Do you think a girl/boy (opposite sex of child) would be able to do that job? Why/why not?

Is it okay for a mother to work outside the house? When?

What types of jobs are women good at?

What types of jobs are men good at?

How much should a father help in looking after the children?

Never Sometimes A Lot

Is it okay for a father to stay home and look after the children? When?

ATTITUDES AND RESPONSES TO ANGER

What kinds of things make you really mad?

How often do you get really mad?

Never Sometimes A Lot

Have you ever felt really mad at someone in your family? When? What did you do?

Have you ever felt really mad at one of your friends? When? What did you do?

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When you re really mad at something or someone, do you ever:
(Circle: 0 = never; 1 = sometimes; 2 = often)

a) yell, scream, swear	0	1	2
b) fight, hit, punch	0	1	2
c) talk to someone	0	1	2
d) walk away	0	1	2
e) go to room	0	1	2
f) other (specify) ________________	0	1	2

If someone your own age teases you, what do you usually do?

Do you also:

a) ignore them _____

b) ask them to stop _____

c) tell someone _____

d) threaten them _____

e) hit them _____

f) other ____________________

If someone your own age takes something without asking, what do you usually do?

Do you also:

a) ignore them _____

b) ask them to stop _____

c) tell someone _____

d) take it back _____

e) threaten them _____

f) hit them _____

g) other ____________________

If someone your own age hits you, what do you usually do?

Do you also:

a) ignore them _____

b) ask them to stop _____

c) tell someone _____

d) threaten them _____

e) hit them _____

f) other ____________________

If your mom or dad does something that you don't like, what do you do?

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If an adult other than your parent does something that you don't like, what do you do?

What do you think is the best way to deal with something when you're really mad?

Do you think this is the best way to solve a problem?

How do you think that most kids your age solve an arguement?

What are your 3 favorite TV shows?

Do people fight in these shows? Give an example.

Do you think this happens in real life?

Of all the characters you have seen on TV, in movies, sports or music, who would you most like to be? Why?

How often do people in the same family hit each other?

Never   Sometimes   A Lot

How often do strangers hit each other?

Never   Sometimes   A Lot

Do you think it's alright for a man to hit a woman? (Why/why not)

(Elicit from child any conditions in which hitting is acceptable)

a) stays out late _____

b) house is messy _____

c) doesn't do as told _____

d) drinking _____

e) self-defense _____

f) other (specify) ______

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Do you think it's alright for a woman to hit a man? (Why/why not)

(Elicit from child any conditions in which hitting is acceptable)

a) stays out late _____
b) house is messy _____
c) doesn't do as told _____
d) drinking _____
e) self-defense _____
f) other (specify)________

Do you think it's alright for a parent to hit a child? (Why/why not)

(Elicit from child any conditions in which hitting is approved)

a) doesn't do as told _____
b) late coming home _____
c) trouble at school _____
d) talks back _____
e) other (specify) _________

CRISIS ADJUSTMENT
(ONLY FOR CHILDREN CURRENTLY RESIDING IN A SHELTER)

How long have you been here at this transition house?

How do you like it here?
Not at all Somewhat A lot

What was the best thing about coming here?

What was the worst thing about coming here?

How did you feel when you first came here to the transition house?

Did you also feel:

a) Sad_____
a) Confused_____
d) Happy_____
e) Angry_____

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c) Scared_____   f) Safe_____

Do you still feel that way (have things got better or worse)?

Have you seen your dad or talked to him since your parents separated?

If yes - how often?

- is that: not enough, too much, just right?

- how did you feel about seeing/talking to him?

If no - do you want to see/talk to your dad? (why/why not)

THE LIFE EVENTS CHECKLIST
(adapted from Johnson and McCutcheon, 1980)

Indicate whether any of the following have happened to you, whether it was a good (G) or bad (B) event, and whether it had no effect (0), a little (1), or a lot (2).

Event	Good/Bad (G/B)	Effect (0/1/2)	Event	Good/Bad (G/B)	Effect (0/1/2)
Moved to new house			New stepparent		
New brother or sister			Parent in jail		
Changed schools			Change in parents financial status		
Serious illness/ injury of family member			Trouble with brother/sister		
Parents divorced			Special recognition for good grades		
More arguments between parents			Joined new club		
Mom/dad lost job			Lost close friend		
			Less arguments		

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Death in family	with parents
Parents separated	Failed grade
Death of a close friend	More arguments with parents
Increased absence of parent from home	Trouble with police
Brother or sister left home	Major personal illness/injury
Serious illness/ injury of close friend	Trouble with teacher
Parent in trouble with the law	Suspended from school
	Failed grades on report card
Parent got a new job	Trouble with classmates

SOCIAL SUPPORT

If you ever had a problem or needed advice, is there someone you could go to for help? Who?

How often do you go to the following people?
(Circle: 0 = never; 1 = sometimes; 2 = often)

Mom	0	1	2	Sibling	0	1	2
Dad	0	1	2	Friend	0	1	2
Grandparent	0	1	2	Aunt/Uncle	0	1	2
Signif. adult	0	1	2	Other (specify)	0	1	2
Teacher	0	1	2				

Do you have any friends whose parents fight the same as yours?

Do you ever talk to them about your parent's fighting?

Do you have any friends whose parents have separated?

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Do you ever talk to them about your parent's separation?

PARENT PERCEPTION INVENTORY
(adapted from Hazzard, Christensen and Margolin, 1981)

We would like to know how much you think your mom and dad do certain things at home. We will not talk to your parents about what you tell us, so please tell us what you really think. (Circle: 0 = never; 1 = sometimes; 2 = often).

First, how often does your mom:	MOM			DAD		
1. Thank you for doing things, tell you when she likes what you did, give you something or let you do something special when you're good.	0	1	2	0	1	2
2. Take away things when you misbehave (like not letting you watch TV or ride your bike or stay up late or eat dessert).	0	1	2	0	1	2
3. Talk to you when you feel bad and help you to feel better, help you with your problems, comfort you.	0	1	2	0	1	2
4. Tell you you're no good. Tell you that you messed up or didn't do something right, criticize you.	0	1	2	0	1	2
5. Talk to you, listen to you, have a good conversation with you.	0	1	2	0	1	2
6. Order you around, tell you what to do, give commands.	0	1	2	0	1	2
7. Let you help decide what to do, let you help figure out how to solve problems.	0	1	2	0	1	2
8. Spank you, slap you, hit you.	0	1	2	0	1	2
9. Play with you, spend time with you, do things with you which you like to do.	0	1	2	0	1	2
10. Get mad at you, yell at you, holler at you, scream at you, shout at you.	0	1	2	0	1	2
11. Say nice things to you, tell you that you're a good girl/boy, compliment you	0	1	2	0	1	2
12. Threaten you, tell you that you'll get into trouble if you do something wrong, warn you.	0	1	2	0	1	2
13. Let you do what other kids your age do, let you do things on your own.	0	1	2	0	1	2

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14. Send you to a room or corner when you do something wrong.	0	1	2	0	1	2
15. Help you when you need it (with a hard job, with homework, when you can't do something by yourself).	0	1	2	0	1	2
16. Nag you, tell you what to do over and over again, keep after you to do things.	0	1	2	0	1	2
17. Hug you, kiss you, tickle you, smile at you.	0	1	2	0	1	2
18. Ignore you, not pay attention to you, not talk to you or look at you.	0	1	2	0	1	2

* Go back and repeat questions for dad.

SAFETY SKILLS

What do you do if mom and dad are arguing?

Do you ever:

a) stay in same room _____

b) leave/hide _____

c) cry _____

d) phone someone _____

e) run out/get someone _____

f) go to older sibling _____

g) make sure siblings OK ____

h) ask parents to stop _____

i) act out _____

j) other (specify) __________

Can you tell when arguing will lead to dad hitting mom? How?

Can you tell when arguing will lead to mom hitting dad? How?

What do you do if dad is hitting mom when you are in the same room?

Do you ever:

a) stay in same room _____

f) go to older sibling _____

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b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____

e) run out/get someone _____ j) other (specify) __________

What do you do if dad is hitting mom when you are in a different room?

Do you ever:

a) stay in same room _____ f) go to older sibling _____

b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____

e) run out/get someone _____ j) other (specify) ________

Has mom or dad ever hit you? Describe.

How often? Never Sometimes A Lot

Do you think you deserved it?

If you were hit by mom or dad, what would you do or what have you do
If you were hit by mom or dad, what would you do or what have you d

Did you also:

a) stay in same room _____ f) go to older sibling _____

b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____
Who?________________

e) run out/get someone _____ j) other (specify) _______

What do you do if mom or dad are hitting your brother or sister?

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Have you ever told anybody about this?
In an emergency (ie. danger to mom/self) who would you call?

Their phone number is: _____________

What would you say?

RESPONSIBILITY FOR VIOLENCE

What do you think mom and dad fight about?

Do they ever fight about you? Describe.

Do they also fight about the following things?
(How often? 0 = never; 1 = sometimes; 2 = often)

a) money? 0 1 2

b) job? 0 1 2

c) drinking? (mom; dad) 0 1 2

d) mom or dad seeing someone else? 0 1 2

e) your brothers or sisters? 0 1 2

f) untidy house? 0 1 2

g) other (specify)? 0 1 2

How does it make you feel to hear them fight about you?

Have you also felt:

a) scared _____

b) sad _____

c) mad _____

d) confused _____

e) other _____

Do you think you could have ever done anything to prevent mom and dad from fighting? If yes, what.

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RESPONSIBILITY FOR PARENTS

Can you think of any time where a child can help her/his parents? When? (ie. dishes)

If mom or dad feels unhappy, do you think you can help them to feel better? How?

Could you also:

a) listen to their problems _____

b) talk to them _____

c) give advice/suggestions _____

d) do extra work around the house _____

e) give them a hug _____

f) don't bug them _____

h) other (specify) ______

How often have you helped mom when she was unhappy?

Never Sometimes A Lot

How often have you helped dad when he was unhappy?

Never Sometimes A Lot

Have your mom or dad ever come to you when they have problems or need advice?

Did you feel that you were able to help them?

How old should someone be when they start:

a) cleaning their own room

b) doing dishes

c) cooking

d) cleaning the house

e) babysitting brothers or sisters by themselves.

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Do you ever worry about your mom? When?

Do you ever worry about your dad? When?

Have you ever felt that your mom or dad asked you to do something that you really weren't able to do? When?

WISHES ABOUT DAD

Is your dad living with you now?

If YES: go on to next section.

If NO: continue questions in this section.

How often do you see your dad or talk to him?

1) daily _____

2) weekly _____

3) bimonthly _____

4) monthly _____

5) never _____

Is this just right ______ too much ___________ too little __________

What kinds of things do you enjoy doing most with your dad?

What do you wish your dad did more often?

What do you wish your dad did less often?

Do you wish that your mom and dad would get back together again? (Why/why not)

Do you think that they will get back together again? When?

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SELF-CONCEPT

What are 3 things you like most about yourself?

What are some things that your parents worry most about you?

Do they also worry about you: a) arguing _____

b) fighting _____

c) being sad _____

d) being shy _____

e) other (specify) ______

Are any of these a problem for you?

Do you have a plan to change these in any way?

If yes, how?

What are some things that your teacher worries most about you?

Does she/he also worry about you:

a) arguing _____

b) fighting _____

c) being sad _____

d) being shy _____

e) other (specify) _______

Are any of these a problem for you?

Do you have a plan to change these in any way?

If yes, how?

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Interviewer:

Rate child's expression of feelings during interview:

Not open	A little open	Somewhat open	Pretty much open	Very very open

---

Comments:

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FEAR SURVEY SCHEDULE FOR CHILDREN - MODIFIED

A NUMBER OF STATEMENTS THAT BOYS AND GIRLS USE TO DESCRIBE THE FEARS THEY HAVE ARE GIVEN BELOW. READ EACH FEAR CAREFULLY AND PUT AN "X" IN THE BOX IN FRONT OF THE WORDS THAT DESCRIBE YOUR FEAR. THERE ARE NO RIGHT AND WRONG ANSWERS. REMEMBER, FIND THE WORDS THAT BEST DESCRIBE HOW MUCH FEAR YOU HAVE.

1. GIVING AN ORAL REPORT [ ] NONE [ ] SOME [ ] A LOT

2. BEING ALONE ON A PLAYGROUND [ ] NONE [ ] SOME [ ] A LOT

3. GETTING PUNISHED BY MOM [ ] NONE [ ] SOME [ ] A LOT

4. LOOKING FOOLISH [ ] NONE [ ] SOME [ ] A LOT

5. PEOPLE WHO SEEM CRAZY [ ] NONE [ ] SOME [ ] A LOT

6. SPEAKING TO POLICE [ ] NONE [ ] SOME [ ] A LOT

7. MEAN LOOKING PEOPLE [ ] NONE [ ] SOME [ ] A LOT

8. TALKING OR THINKING ABOUT SEX [ ] NONE [ ] SOME [ ] A LOT

9. GETTING SICK AT SCHOOL [ ] NONE [ ] SOME [ ] A LOT

10. WATCHING PEOPLE KISS ON TV [ ] NONE [ ] SOME [ ] A LOT

11. SOMEONE KISSING OR HUGGING ME [ ] NONE [ ] SOME [ ] A LOT

12. BEING TEASED [ ] NONE [ ] SOME [ ] A LOT

13. NAKED PEOPLE [ ] NONE [ ] SOME [ ] A LOT

14. BEING CALLED ON BY A TEACHER [ ] NONE [ ] SOME [ ] A LOT

15. GETTING POOR GRADES [ ] NONE [ ] SOME [ ] A LOT

16. TAKING MY CLOTHES OFF [ ] NONE [ ] SOME [ ] A LOT

17. MY PARENTS CRITICIZING ME [ ] NONE [ ] SOME [ ] A LOT

18. DOING SOMETHING THAT IS NASTY [ ] NONE [ ] SOME [ ] A LOT

19. BEING TICKLED [ ] NONE [ ] SOME [ ] A LOT

20. PEOPLE NOT BELIEVING ME [ ] NONE [ ] SOME [ ] A LOT

21. HAVING TO EAT FOODS I DON'T LIKE [ ] NONE [ ] SOME [ ] A LOT

22. HAVING OLDER BOYS OR MEN LOOK AFTER ME ALONE [ ] NONE [ ] SOME [ ] A LOT

23. FAILING A TEST [ ] NONE [ ] SOME [ ] A LOT

24. HAVING MY PARENTS ARGUE [ ] NONE [ ] SOME [ ] A LOT

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25.	HAVING TO PUT ON A RECITAL	[ ] NONE	[ ] SOME	[ ] A LOT
26.	BEING CRITICIZED BY OTHERS	[ ] NONE	[ ] SOME	[ ] A LOT
27.	TAKING A BATH	[ ] NONE	[ ] SOME	[ ] A LOT
28.	GETTING A REPORT CARD	[ ] NONE	[ ] SOME	[ ] A LOT
29.	SLEEPING ALONE	[ ] NONE	[ ] SOME	[ ] A LOT
30.	TELLING ON SOMEONE FOR BOTHERING ME	[ ] NONE	[ ] SOME	[ ] A LOT
31.	SAYING "NO" TO AN ADULT	[ ] NONE	[ ] SOME	[ ] A LOT
32.	MOM FINDING OUT ABOUT SOMETHING I DID	[ ] NONE	[ ] SOME	[ ] A LOT
33.	SOMEONE IN MY FAMILY GETTING INTO BAD TROUBLE	[ ] NONE	[ ] SOME	[ ] A LOT
34.	HAVING TO WEAR CLOTHES DIFFERENT FROM OTHERS	[ ] NONE	[ ] SOME	[ ] A LOT
35.	GETTING PUNISHED BY MY FATHER	[ ] NONE	[ ] SOME	[ ] A LOT
36.	BEING LIED TO BY SOMEONE I TRUST	[ ] NONE	[ ] SOME	[ ] A LOT
37.	MAKING MISTAKES	[ ] NONE	[ ] SOME	[ ] A LOT
38.	BEING TOLD TO DO SOMETHING I SHOULDN'T DO	[ ] NONE	[ ] SOME	[ ] A LOT
39.	GOING TO COURT TO TALK TO A JUDGE	[ ] NONE	[ ] SOME	[ ] A LOT
40.	BEING BLAMED UNFAIRLY	[ ] NONE	[ ] SOME	[ ] A LOT
41.	BEING TAKEN AWAY FROM MY PARENTS	[ ] NONE	[ ] SOME	[ ] A LOT
42.	PEOPLE KNOWING BAD THINGS ABOUT ME	[ ] NONE	[ ] SOME	[ ] A LOT
43.	SOMEONE GETTING DRUNK	[ ] NONE	[ ] SOME	[ ] A LOT
44.	MOM NOT AT HOME	[ ] NONE	[ ] SOME	[ ] A LOT
45.	TAKING A TEST	[ ] NONE	[ ] SOME	[ ] A LOT

PLEASE INDICATE ANY ADDITIONAL FEARS:

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APPENDIX H

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POST-GROUP INTERVIEW WITH MOM

Interviewer ________________ Today's date ____________________________

Location ____________________ Date of last interview ____________

1. Mother's full name: ______________________________ Age: ______

2. Name of child(ren) who participated in the group:

   a) ___________________________________ Age ______

   b) ___________________________________ Age ______

   c) ___________________________________ Age ______

3. How many group sessions did child attend? ______

4. If child was in a second session of groups, how many weeks were there from the end of the first groups and the beginning of the second group?

   ____

5. Since our last interview, have you:

   a) changed residence ____

   b) children changed schools ____

   c) had any change in your marital status _________________________

   d) had any other life changes ______________________________________

6. Has anyone in your family ever sought any help for family or personal problems since our previous interview? Please indicate whether the counselling is finished or ongoing.

Person	Type of counseling (ie. group, couple, individual)	# Sessions	Approx. date of involvement

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5. Do you think your child has enjoyed participating in the group?

Not at all _____ A little _____ A lot _____

5b. If yes, in what way? ______________________________________

____

6. Do you think your child has learned anything from the group?

Yes _____ No _____ Don't know _____

Describe: ____

____

7. Have you noticed any changes in your child's behavior since he/she started the group?

Worse _____ No change _____ Better _____

Describe: ____

____

8. Do you have any other comments or suggestions about your child's participation in the group?

----

9. If your marital status has changed since our last interview, are you now:

reunited with abusive partner_____ with a different partner_____ single_____

10. If with the same partner (as of our last interview), what has been the rate of violence over the past 3 months?

stopped_____ decreased_____ same_____ increased_____

11. If with a different partner (than abusive partner) has there been any violence ?

yes_____ no_____

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CHILD BEHAVIOR CHECKLIST FOR AGES 4-16

For office use only
ID #

CHILD'S NAME (1-5) (6,7:01)

SEX ☐ Boy 1 ☐ Girl 2 (8) | AGE (9-10)

TODAY'S DATE Mo. ______ Day ______ Yr. ______ | CHILD'S BIRTHDATE Mo. ______ Day ______ Yr. ______

GRADE IN SCHOOL (11-16:BLANK)

THIS FORM FILLED OUT BY:
☐ Mother
☐ Father
☐ Other *(Specify)*

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

(17: 0-3)

	Compared to other children of the same age, about how much time does he/she spend in each?					Compared to other children of the same age, how well does he/she do each one?				
	Don't Know 9	Less Than Average 1	Average 2	More Than Average 3		Don't Know 9	Below Average 1	Average 2	Above Average 3	
a. ______	☐	☐	☐	☐	(18)	☐	☐	☐	☐	(21)
b. ______	☐	☐	☐	☐	(19)	☐	☐	☐	☐	(22)
c. ______	☐	☐	☐	☐	(20)	☐	☐	☐	☐	(23)

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.)

☐ None

(24: 0-3)

	Compared to other children of the same age, about how much time does he/she spend in each?					Compared to other children of the same age, how well does he/she do each one?				
	Don't Know 9	Less Than Average 1	Average 2	More Than Average 3		Don't Know 9	Below Average 1	Average 2	Above Average 3	
a. ______	☐	☐	☐	☐	(25)	☐	☐	☐	☐	(28)
b. ______	☐	☐	☐	☐	(26)	☐	☐	☐	☐	(29)
c. ______	☐	☐	☐	☐	(27)	☐	☐	☐	☐	(30)

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

(31: 0-3)

	Compared to other children of the same age, how active is he/she in each?				
	Don't Know 9	Less Active 1	Average 2	More Active 3	
a. ______	☐	☐	☐	☐	(32)
b. ______	☐	☐	☐	☐	(33)
c. ______	☐	☐	☐	☐	(34)

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc.

☐ None

(35: 0-3)

	Compared to other children of the same age, how well does he/she carry them out?				
	Don't Know 9	Below Average 1	Average 2	Above Average 3	
a. ______	☐	☐	☐	☐	(36)
b. ______	☐	☐	☐	☐	(37)
c. ______	☐	☐	☐	☐	(38)

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3-81 Edition

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VIII. Below is a list of items that describe children. For each item that describes your child *now* or *within the past 6 months*, please circle the *2* if the item is *very true* or *often true* of your child. Circle the *1* if the item is *somewhat* or *sometimes true* of your child. If the item is *not true* of your child, circle the *0*.

1 2 1. Acts too young for his/her age 16
1 2 2. Allergy (describe): ______

______

1 2 3. Argues a lot
1 2 4. Asthma

1 2 5. Behaves like opposite sex 20
1 2 6. Bowel movements outside toilet

1 2 7. Bragging, boasting
1 2 8. Can't concentrate, can't pay attention for long

1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): ______

______

1 2 10. Can't sit still, restless, or hyperactive 25

1 2 11. Clings to adults or too dependent
1 2 12. Complains of loneliness

1 2 13. Confused or seems to be in a fog
1 2 14. Cries a lot

1 2 15. Cruel to animals 30
1 2 16. Cruelty, bullying, or meanness to others

1 2 17. Day-dreams or gets lost in his/her thoughts
1 2 18. Deliberately harms self or attempts suicide

1 2 19. Demands a lot of attention
1 2 20. Destroys his/her own things 35

1 2 21. Destroys things belonging to his/her family or other children
1 2 22. Disobedient at home

1 2 23. Disobedient at school
1 2 24. Doesn't eat well

1 2 25. Doesn't get along with other children 40
1 2 26. Doesn't seem to feel guilty after misbehaving

1 2 27. Easily jealous
1 2 28. Eats or drinks things that are not food (describe): ______

______

1 2 29. Fears certain animals, situations, or places, other than school (describe): ______

______

1 2 30. Fears going to school 45

0 1 2 31. Fears he/she might think or do something bad

0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her

0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior 50

0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights

0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with children who get in trouble

0 1 2 40. Hears things that aren't there (describe): ______

______ 55

0 1 2 41. Impulsive or acts without thinking

0 1 2 42. Likes to be alone
0 1 2 43. Lying or cheating

0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense 60

0 1 2 46. Nervous movements or twitching (describe): ______

______

0 1 2 47. Nightmares

0 1 2 48. Not liked by other children
0 1 2 49. Constipated, doesn't move bowels

0 1 2 50. Too fearful or anxious 65
0 1 2 51. Feels dizzy

0 1 2 52. Feels too guilty
0 1 2 53. Overeating

0 1 2 54. Overtired
0 1 2 55. Overweight 70

56. Physical problems without known medical cause:
0 1 2 a. Aches or pains
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (describe): ______

______

0 1 2 e. Rashes or other skin problems 75
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): ______

______

Please see other side

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0 1 2 57. Physically attacks people

0 1 2 58. Picks nose, skin, or other parts of body (describe): ____________

____________ 80

0 1 2 59. Plays with own sex parts in public 16

0 1 2 60. Plays with own sex parts too much

0 1 2 61. Poor school work

0 1 2 62. Poorly coordinated or clumsy

0 1 2 63. Prefers playing with older children 20

0 1 2 64. Prefers playing with younger children

0 1 2 65. Refuses to talk

0 1 2 66. Repeats certain acts over and over; compulsions (describe): ____________

____

0 1 2 67. Runs away from home

0 1 2 68. Screams a lot 25

0 1 2 69. Secretive, keeps things to self

0 1 2 70. Sees things that aren't there (describe):

____

____

0 1 2 71. Self-conscious or easily embarrassed

0 1 2 72. Sets fires

0 1 2 73. Sexual problems (describe):

____

____________ 30

0 1 2 74. Showing off or clowning

0 1 2 75. Shy or timid

0 1 2 76. Sleeps less than most children

0 1 2 77. Sleeps more than most children during day and/or night (describe): ____________

____

0 1 2 78. Smears or plays with bowel movements 35

0 1 2 79. Speech problem (describe): ____________

____

0 1 2 80. Stares blankly

0 1 2 81. Steals at home

0 1 2 82. Steals outside the home

0 1 2 83. Stores up things he/she doesn't need (describe):

____________ 40

0 1 2 84. Strange behavior (describe): ____________

____

0 1 2 85. Strange ideas (describe):

____

0 1 2 86. Stubborn, sullen, or irritable

0 1 2 87. Sudden changes in mood or feelings

0 1 2 88. Sulks a lot 45

0 1 2 89. Suspicious

0 1 2 90. Swearing or obscene language

0 1 2 91. Talks about killing self

0 1 2 92. Talks or walks in sleep (describe):

____

0 1 2 93. Talks too much 50

0 1 2 94. Teases a lot

0 1 2 95. Temper tantrums or hot temper

0 1 2 96. Thinks about sex too much

0 1 2 97. Threatens people

0 1 2 98. Thumb-sucking 55

0 1 2 99. Too concerned with neatness or cleanliness

0 1 2 100. Trouble sleeping (describe):

____

0 1 2 101. Truancy, skips school

0 1 2 102. Underactive, slow moving, or lacks energy

0 1 2 103. Unhappy, sad, or depressed 60

0 1 2 104. Unusually loud

0 1 2 105. Uses alcohol or drugs (describe):

____

0 1 2 106. Vandalism

0 1 2 107. Wets self during the day

0 1 2 108. Wets the bed 65

0 1 2 109. Whining

0 1 2 110. Wishes to be of opposite sex

0 1 2 111. Withdrawn, doesn't get involved with others

0 1 2 112. Worrying

113. Please write in any problems your child has that were not listed above:

0 1 2 ____________ 70

0 1 2 ____________

0 1 2 ____________

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

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APPENDIX I

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CHILD INTERVIEW - POST GROUP

Child's Name:________________ Date:____________

Location:________________ Interviewer:__________

THE LIFE EVENTS CHECKLIST

(adapted from Johnson and McCutcheon, 1980)

Indicate whether any of the following have happened to you, whether it was a good (G) or bad (B) event, and whether it had no effect (0), a little (1), or a lot (2).

Event	Good/Bad (G/B)	Effect (0/1/2)	Event	Good/Bad (G/B)	Effect (0/1/2)
Moved to new house			New stepparent		
New brother or sister			Parent in jail		
Changed schools			Change in parents financial status		
Serious illness/ injury of family member			Trouble with brother/sister		
Parents divorced			Special recognition for good grades		
More arguments between parents			Joined new club		
Mom/dad lost job			Lost close friend		
Death in family			Less arguments with parents		
Parents separated			Failed grade		
Death of a close friend			More arguments with parents		
Increased absence of parent from home			Trouble with police		
Brother or sister left home			Major personal illness/injury		
Serious illness/ injury of close friend			Trouble with teacher		
			Suspended from school		

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CHILD INTERVIEW - POST GROUP

Child's Name:____________________ Date:______________

Location:________________________ Interviewer:____________

THE LIFE EVENTS CHECKLIST
(adapted from Johnson and McCutcheon, 1980)

Indicate whether any of the following have happened to you, whether it was a good (G) or bad (B) event, and whether it had no effect (0), a little (1), or a lot (2).

Event	Good/Bad (G/B)	Effect (0/1/2)	Event	Good/Bad (G/B)	Effect (0/1/2)
Moved to new house			New stepparent		
New brother or sister			Parent in jail		
Changed schools			Change in parents financial status		
Serious illness/ injury of family member			Trouble with brother/sister		
Parents divorced			Special recognition for good grades		
More arguments between parents			Joined new club		
Mom/dad lost job			Lost close friend		
Death in family			Less arguments with parents		
Parents separated			Failed grade		
Death of a close friend			More arguments with parents		
Increased absence of parent from home			Trouble with police		
Brother or sister left home			Major personal illness/injury		
Serious illness/ injury of close friend			Trouble with teacher		
			Suspended from school		

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Parent in trouble with the law	Failed grades on report card
Parent got a new job	Trouble with classmates

SOCIAL SUPPORT

If you ever had a problem or needed advice, is there someone you could go to for help? Who?

How often do you go to the following people?
(Circle: 0 = never; 1 = sometimes; 2 = often)

Mom	0	1	2	Sibling	0	1	2
Dad	0	1	2	Friend	0	1	2
Grandparent	0	1	2	Aunt/Uncle	0	1	2
Signif. adult	0	1	2	Other	0	1	2
Teacher	0	1	2				

Do you have any friends whose parents fight the same as yours?

Do you ever talk to them about your parent's fighting?

Do you have any friends whose parents have separated?

Do you ever talk to them about your parent's separation?

SAFETY SKILLS

What do you do if mom and dad are arguing?

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Do you ever:

a) stay in same room _____ f) go to older sibling _____

b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____

e) run out/get someone _____ j) other _____________________

Can you tell when arguing will lead to dad hitting mom? How?

Can you tell when arguing will lead to mom hitting dad? How?

What do you do if dad is hitting mom when you are in the same room?

Do you ever:

a) stay in same room _____ f) go to older sibling _____

b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____

e) run out/get someone _____ j) other _____________________

What do you do if dad is hitting mom when you are in a different room?

a) stay in same room _____ f) go to older sibling _____

b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____

e) run out/get someone _____ j) other _____________________

Has mom or dad ever hit you? Describe.

How often? Never Sometimes A Lot

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Do you think you deserved it?

If you were hit by mom or dad, what would you do or what have you done?

Did you also:

a) stay in same room _____ f) go to older sibling _____

b) leave/hide _____ g) make sure siblings OK ____

c) cry _____ h) ask parents to stop _____

d) phone someone _____ i) act out _____

e) run out/get someone _____ j) other ________________

What do you do if mom or dad are hitting your brother or sister?

Have you ever told anybody about this?

In an emergency (ie. danger to mom/self) who would you call?

Their phone number is: _______________

What would you say?

RESPONSIBILITY FOR VIOLENCE

What do you think mom and dad fight about?

Do they also fight about the following things?
(How often? 0 = never; 1 = sometimes; 2 = often)

a) money? 0 1 2

b) job? 0 1 2

c) drinking? (mom; dad) 0 1 2

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d) mom or dad seeing someone else? 0 1 2

e) your brothers or sisters? 0 1 2

f) untidy house? 0 1 2

g) other (specify)? 0 1 2

h) you? 0 1 2

How does it make you feel to hear them fight about you?

a) scared _____ d) confused _____

b) sad _____ e) other _____

c) mad _____

Do you think you could have ever done anything to prevent mom and dad from fighting? If yes, what.

RESPONSIBILITY FOR PARENTS

Can you think of any time where a child can help her/his parents? When? (ie. dishes)

If mom or dad feels unhappy, do you think you can help them to feel better? How?

Could you also:

a) listen to their problems _____ e) give them a hug _____

b) talk to them _____ f) don't bug them _____

c) give advice/suggestions _____ h) other _______________

d) do extra work around the house _____

How often have you helped mom when she was unhappy?

Never Sometimes A Lot

How often have you helped dad when he was unhappy?

Never Sometimes A Lot

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Have your mom or dad ever come to you when they have problems or need advice?

Did you feel that you were able to help them?

How old should someone be when they start:

a) cleaning their own room

b) doing dishes

c) cooking

d) cleaning the house

e) babysitting brothers or sisters by themselves.

Do you ever worry about your mom? When?

Do you ever worry about your dad? When?

Have you ever felt that your mom or dad asked you to do something that you really weren't able to do? When?

WISHES IN REGARD TO DAD (Just for separated kids)

Is your dad living with you now?

If YES: go on to next section.

If NO: continue questions in this section.

How often do you see your dad or talk to him?

1) daily _____

2) weekly _____

3) bimonthly _____

4) monthly _____

5) never _____

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Is this just right ______ too much ______ too little ____

What kinds of things do you enjoy doing most with your dad?

What do you wish your dad did more often?

What do you wish your dad did less often?

Do you wish that your mom and dad would get back together again? (Why/why not)

Do you think that they will get back together again? When?

SEXUAL STEREOTYPING

How are boys different from girls?

How are girls different from boys?

What would you like to be when you grow up?

Do you think a girl/boy (opposite sex of child) would be able to do that job? Why/why not?

Is it okay for a mother to work outside the house? When?

What types of jobs are women good at?

What types of jobs are men good at?

How much should a father help in looking after the children?

Never Sometimes A Lot

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Is it okay for a father to stay home and look after the children? When?

ATTITUDES AND RESPONSES TO ANGER

What kinds of things make you really mad?

How often do you get really mad?

Never Sometimes A Lot

Have you ever felt really mad at someone in your family? When? What did you do?

Have you ever felt really mad at one of your friends? When? What did you do?

When you're really mad at something or someone, do you ever:
(Circle: 0 = never; 1 = sometimes; 2 = often)

a) yell, scream, swear	0	1	2
b) fight, hit, punch	0	1	2
c) talk to someone	0	1	2
d) walk away	0	1	2
e) go to room	0	1	2
f) other.	0	1	2

If someone your own age teases you, what do you usually do?

Do you also:

a) ignore them ______ d) threaten them ______

b) ask them to stop ______ e) hit them ______

c) tell someone ______ f) other ______________________

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If someone your own age takes something without asking, what do you usually do?

Do you also:

a) ignore them _____

b) ask them to stop _____

c) tell someone _____

d) take it back _____

e) threaten them _____

f) hit them _____

g) other ____________________

If someone your own age hits you, what do you usually do?

Do you also:

a) ignore them _____

b) ask them to stop _____

c) tell someone _____

d) threaten them _____

e) hit them _____

f) other ____________________

If your mom or dad does something that you don't like, what do you do?

If an adult other than your parent does something that you don't like, what do you do?

What do you think is the best way to deal with something when you're really mad?

Do you think this is the best way to solve a problem?

How do you think that most kids your age solve an arguement?

What are your 3 favorite TV shows?

Do people fight in these shows? Give an example.

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Do you think this happens in real life?

Of all the characters you have seen on TV, in movies, sports, or music, who would you most like to be? Why?

How often do people in the same family hit each other?

Never Sometimes A Lot

How often do strangers hit each other?

Never Sometimes A Lot

Do you think it's alright for a man to hit a woman? (Why/why not)

(Elicit from child any conditions in which hitting is acceptable)

a) stays out late _____ d) drinking _____

b) house is messy _____ e) self-defense _____

c) doesn't do as told _____ f) other ________________

Do you think it's alright for a woman to hit a man? (Why/why not)

(Elicit from child any conditions in which hitting is acceptable)

a) stays out late _____ d) drinking _____

b) house is messy _____ e) self-defense _____

c) doesn't do as told _____ f) other ________________

Do you think it's alright for a parent to hit a child? (Why/why not)

(Elicit from child any conditions in which hitting is approved)

a) doesn't do as told _____ d) talks back _____

b) late coming home _____ e) other ________________

c) trouble at school _____

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SELF-CONCEPT

What are 3 things you like most about yourself?

What are some things that your parents worry most about you?

Do they also worry about you: a) arguing _____

b) fighting _____

c) being sad _____

d) being shy _____

e) other _______________________

Are any of these a problem for you?

Do you have a plan to change these in any way?

If yes, how?

What are some things that your teacher worries most about you?

Does she/he also worry about you:

a) arguing _____

b) fighting _____

c) being sad _____

d) being shy _____

e) other _______________________

Are any of these a problem for you?

Do you have a plan to change these in any way?

If yes, how?

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PROGRAM EVALUATION

What did you like most about the group?

Overall, how much did you enjoy the group?

Not at all   A little   A Lot

What did you like least about the group?

Name the 3 most important things that you learned while in the group.

Overall, how much did you learn from the group?

Nothing   A Little   A Lot

What would be helpful for other kids from the same situation as yours to know?

Have you been in other groups before this one?

If NO: go to next question.

If YES: describe ______________________________
____
____

Compared to other groups, was this one:

worse _____   same _____   better _____

Do you have any other comments or suggestions you would like to make?

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Interviewer:

Rate child's expression of feelings during interview:

Not open	A little open	Somewhat open	Pretty much open	Very open

---

Comments:

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FEAR SURVEY SCHEDULE FOR CHILDREN - MODIFIED

A NUMBER OF STATEMENTS THAT BOYS AND GIRLS USE TO DESCRIBE THE FEARS THEY HAVE ARE GIVEN BELOW. READ EACH FEAR CAREFULLY AND PUT AN "X" IN THE BOX IN FRONT OF THE WORDS THAT DESCRIBE YOUR FEAR. THERE ARE NO RIGHT AND WRONG ANSWERS. REMEMBER, FIND THE WORDS THAT BEST DESCRIBE HOW MUCH FEAR YOU HAVE.

1.	GIVING AN ORAL REPORT	[ ] NONE	[ ] SOME	[ ] A LOT
2.	BEING ALONE ON A PLAYGROUND	[ ] NONE	[ ] SOME	[ ] A LOT
3.	GETTING PUNISHED BY MOM	[ ] NONE	[ ] SOME	[ ] A LOT
4.	LOOKING FOOLISH	[ ] NONE	[ ] SOME	[ ] A LOT
5.	PEOPLE WHO SEEM CRAZY	[ ] NONE	[ ] SOME	[ ] A LOT
6.	SPEAKING TO POLICE	[ ] NONE	[ ] SOME	[ ] A LOT
7.	MEAN LOOKING PEOPLE	[ ] NONE	[ ] SOME	[ ] A LOT
8.	TALKING OR THINKING ABOUT SEX	[ ] NONE	[ ] SOME	[ ] A LOT
9.	GETTING SICK AT SCHOOL	[ ] NONE	[ ] SOME	[ ] A LOT
10.	WATCHING PEOPLE KISS ON TV	[ ] NONE	[ ] SOME	[ ] A LOT
11.	SOMEONE KISSING OR HUGGING ME	[ ] NONE	[ ] SOME	[ ] A LOT
12.	BEING TEASED	[ ] NONE	[ ] SOME	[ ] A LOT
13.	NAKED PEOPLE	[ ] NONE	[ ] SOME	[ ] A LOT
14.	BEING CALLED ON BY A TEACHER	[ ] NONE	[ ] SOME	[ ] A LOT
15.	GETTING POOR GRADES	[ ] NONE	[ ] SOME	[ ] A LOT
16.	TAKING MY CLOTHES OFF	[ ] NONE	[ ] SOME	[ ] A LOT
17.	MY PARENTS CRITICIZING ME	[ ] NONE	[ ] SOME	[ ] A LOT
18.	DOING SOMETHING THAT IS NASTY	[ ] NONE	[ ] SOME	[ ] A LOT
19.	BEING TICKLED	[ ] NONE	[ ] SOME	[ ] A LOT
20.	PEOPLE NOT BELIEVING ME	[ ] NONE	[ ] SOME	[ ] A LOT
21.	HAVING TO EAT FOODS I DON'T LIKE	[ ] NONE	[ ] SOME	[ ] A LOT
22.	HAVING OLDER BOYS OR MEN LOOK AFTER ME ALONE	[ ] NONE	[ ] SOME	[ ] A LOT
23.	FAILING A TEST	[ ] NONE	[ ] SOME	[ ] A LOT
24.	HAVING MY PARENTS ARGUE	[ ] NONE	[ ] SOME	[ ] A LOT

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25. HAVING TO PUT ON A RECITAL [ ] NONE [ ] SOME [ ] A LOT

26. BEING CRITICIZED BY OTHERS [ ] NONE [ ] SOME [ ] A LOT

27. TAKING A BATH [ ] NONE [ ] SOME [ ] A LOT

28. GETTING A REPORT CARD [ ] NONE [ ] SOME [ ] A LOT

29. SLEEPING ALONE [ ] NONE [ ] SOME [ ] A LOT

30. TELLING ON SOMEONE FOR BOTHERING ME [ ] NONE [ ] SOME [ ] A LOT

31. SAYING "NO" TO AN ADULT [ ] NONE [ ] SOME [ ] A LOT

32. MOM FINDING OUT ABOUT SOMETHING I DID [ ] NONE [ ] SOME [ ] A LOT

33. SOMEONE IN MY FAMILY GETTING INTO BAD TROUBLE [ ] NONE [ ] SOME [ ] A LOT

34. HAVING TO WEAR CLOTHES DIFFERENT FROM OTHERS [ ] NONE [ ] SOME [ ] A LOT

35. GETTING PUNISHED BY MY FATHER [ ] NONE [ ] SOME [ ] A LOT

36. BEING LIED TO BY SOMEONE I TRUST [ ] NONE [ ] SOME [ ] A LOT

37. MAKING MISTAKES [ ] NONE [ ] SOME [ ] A LOT

38. BEING TOLD TO DO SOMETHING I SHOULDN'T DO [ ] NONE [ ] SOME [ ] A LOT

39. GOING TO COURT TO TALK TO A JUDGE [ ] NONE [ ] SOME [ ] A LOT

40. BEING BLAMED UNFAIRLY [ ] NONE [ ] SOME [ ] A LOT

41. BEING TAKEN AWAY FROM MY PARENTS [ ] NONE [ ] SOME [ ] A LOT

42. PEOPLE KNOWING BAD THINGS ABOUT ME [ ] NONE [ ] SOME [ ] A LOT

43. SOMEONE GETTING DRUNK [ ] NONE [ ] SOME [ ] A LOT

44. MOM NOT AT HOME [ ] NONE [ ] SOME [ ] A LOT

45. TAKING A TEST [ ] NONE [ ] SOME [ ] A LOT

PLEASE INDICATE ANY ADDITIONAL FEARS:

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VITA AUCTORIS

Peter Dirks was born on September 25th, 1949 in Geislingen, West Germany. In 1952, he immigrated to Canada with his family. He attended elementary school in New Hamburg and completed his secondary schooling at Eastwood Collegiate Institute in Kitchener. Mr. Dirks studied at the University of Waterloo from 1969 to 1972, when he graduated with the degree of Bachelor or Arts (Psychology).

Mr. Dirks worked as a mental retardation counsellor and a psychiatric counsellor for periods of time, before starting employment as a caseworker with the Social Services Department of the Regional Municipality of Waterloo. Mr. Dirks was an income maintenance caseworker for six and half years before deciding to return to school.

In 1983, Mr. Dirks was accepted as a Special Fourth year student at the School of Social Work, University of Windsor, and graduated with a Bachelor of Social Work degree in 1984. He entered the University of Windsor's Master of Social Work program as a part-time student in September, 1984, and expects to graduate in June, 1987.

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Mr. Dirks completed field placements at Southwest Detroit Community Mental Health Inc., and the Custody and Access Project in London, Ontario. While pursuing his studies in the Master of Social Work program, Mr. Dirks was employed as a social worker for two children's aid societies. Currently, he is employed as a social worker with Southwestern Regional Center in Sarnia, Ontario.

During the fall semester of 1986, Mr. Dirks was employed by the Data Bank Research group as a research assistant. Mr. Dirks, in conjunction with seven other authors, compiled an annotated bibliography for the Data Bank Research group. This work, entitled, "An Annotated Bibliography of Studies Related to The Windsor Economy 1975-1985", was published by the University of Windsor in March, 1987.

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