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Changes in Self Esteem and Anxiety in Children in a Group Program for Witnesses of Wife Assault

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Changes in Self-Esteem and Anxiety in Children in a Group Program for Witnesses of Wife Assault" submitted by Gillian M. Cox in partial fulfillment of the requirements for the degree of Master of Social Work.

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Abstract

This study examined changes in self-reported anxiety and self-esteem levels of children aged 5-13 who participated in a group counselling program for witnesses of wife assault. Using a pre-test /post-test design, significant decreases in anxiety, as measured by the Revised Children's Manifest Anxiety Scale, were reported by the children - especially among the 5-7 year olds. No significant changes were reported by the 8-13 year old children on the Piers-Harris Children's Self-Concept Scale, but the 5-7 year old children who were themselves abused did report significantly higher self-esteem scores on the McDaniel-Piers Young Children's Self-Concept Scale at post-test. The results of a supplemental telephone survey of the mothers indicated that most of the children were calmer, and many expressed their feelings more following the group counselling program.

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INTRODUCTION

When I worked as a crisis counsellor at a women's emergency shelter, friends used to ask me, "How can you do that sort of work? Doesn't it bother you - seeing all those beaten up women, and hearing their violent stories?" I would always give the same answer, replying that, yes, it did bother me, but I felt that I was helping in some small way, and I had found ways of leaving my work behind at the end of the day. However, I always tacked on to the end of this statement ,"but ... sometimes I do have a really hard time seeing what the violence does to the children". For, despite my best efforts, there were days when I did come home with a heavy heart for the innocent victims of family violence: the children whose daily lives were filled with violence, abuse, and neglect. I believe that having a preschooler of my own, whose life has so far been untouched by violence, has deepened my feelings of empathy for children who witness wife abuse.

While I continue to feel horrified at the interparental violence to which many children are exposed, at the same time I also believe in the strength of the human spirit to survive in the most adverse circumstances. My social work experience, which has included counselling survivors of child sexual abuse, has proven to me that both children and adults can heal from trauma.

It was, thus, with a strong feeling of empathy for child witnesses of wife abuse, and a firm belief in their potential to survive and heal, that I embarked upon the present research project. In general, I was interested in exploring the extent to which counselling and support can assist child witnesses to cope with

family violence, and whether or not such treatment can help to ameliorate some of its adverse effects.

CHAPTER ONE

WIFE ASSAULT AND ITS EFFECTS UPON CHILDREN

> My parents have been fighting ever since I can remember. They used to have some happy times, but then the fighting would always start again. When I was a kid, I used to wish the happy times would last, but they never did. After a while I couldn't decide which was worse, the fights or the so-called good times. I wanted to throw up when they were nice to each other. How could she kiss him when he'd been bashing her the day before?...Nothing makes sense. I know one thing, though, I'm not going to have any kids, not ever. I'd probably beat them, too. I went to a doctor to see if I could get a vasectomy, but he told me I'm too young. If I can't do that, I can at least get away from here and never come back"
> -excerpt of a letter written by the 17 year old son of an abusive couple (Office for the Prevention of Family Violence, 1991, p. 33).

In the last two and a half decades, there has been an unprecedented level of public and media attention devoted to the issue of family violence. Researchers have documented the incidence of family violence, governments have sponsored task forces to carry out their own studies of the issue, and women's shelters have been set up across the country to offer temporary protection to women and children from the violence they experience in their lives.

At the outset of the movement to offer aid to victims of family violence, service providers focused on helping battered women to escape from their abusive situations. When women arrived at transition houses, they were

typically given assistance so that they could live independently from their partners (MacLeod, 1987). However, between 33 and 50% of women who were housed in shelters ended up returning to their abusive partners despite the efforts of service providers (Westhues, 1989). It became clear that focusing solely on helping the women to leave was not meeting the needs of the women themselves, their children, nor the men to whom many women returned. The emphasis on crisis intervention, while necessary and vital, also did little to prevent further violence from occurring. More recently, however, in the attempt to offer more comprehensive and effective services in the area of family violence, many social agencies have made an effort to provide treatment to the batterers, to the women and the batterers together, and to the children of the family (MacLeod, 1987).

This particular study focuses upon one such program - it explores the impact of a group counselling program on child witnesses of violence, offered at the Calgary Y.W.C.A.'s Support Centre - Alternatives to Domestic Abuse Program.

The purpose of this chapter is to discuss the incidence of wife assault in North American society, the theories which attempt to explain the occurrence of wife assault, and finally, the effects upon children who witness this type of violence.

The Incidence of Wife Assault

Dobash and Dobash (1979) argue that in order to understand the problem of wife beating, it is essential to understand the historical and cultural context in which it occurs. These sociologists give evidence of the subordination of women and of wife beating throughout the centuries, noting

that, "women's place in history often has been at the receiving end of a blow" (p. 31). For instance, in the Bible, Eve was punished for eating the forbidden fruit, and other passages in the book of Genesis support a husband's right to rule over his wife. The Romans sanctioned a husband's right to chastise, divorce, or kill his wife. The origins of the "rule of thumb" idiom date back to English common-law of the 18th century, where it was stated that a husband could beat his wife as long as the stick was no thicker than his thumb. It was only in the late 19th century that specific laws prohibiting wife beating were introduced in some American states (Gelles & Cornell, 1990). These are but a few examples which demonstrate that the problem of family violence has existed throughout history. However, it is only in recent times that the problem has been widely researched and publicized.

Recent research has revealed wife assault to be a pervasive problem in Canadian society, for example, one study noted that 27% of the 420 women interviewed in a random sample reported an experience of physical abuse in an intimate relationship with a husband, live-in partner, boyfriend, or date (The Canadian Panel on Violence Against Women, 1993). In 36% of the cases, women who had been physically assaulted also reported that they were afraid that their partner would kill them. A recent Statistics Canada survey of 12,300 women found that 25% of Canadian women have been victimized by a current or past marital partner (Statistics Canada, 1993). It is noteworthy that Alberta had the second highest rate of violence against women in Canada. These figures, in general, are higher than a previous estimate that at least one in ten Canadian women are abused every year by the man with whom they live (MacLeod, 1987).

Researchers in the United States have reported similarly high rates of wife assault. One of the most publicized studies, the first American national survey on family violence, was carried out in 1976 by Straus, Gelles, and Steinmetz (1980). These researchers found that 28% of women had been the victim of some form of physical violence at some point during their marriage. Furthermore, the authors point out that because of the methodological challenges inherent in this type of research, this figure is probably an underestimate of the actual level of family violence. Overall, estimates suggest that at least 3 to 4 million American households live with family violence every year (Jaffe,Wolfe, & Wilson,1990).

Clearly, for many women, the family is not a "safe haven", but rather a place where they are at high risk of being physically injured, maimed, and even killed. As Dobash and Dobash (1979) state, "the fact is that for most people, and especially for women and children, the family is the most violent group to which they are likely to belong. Despite fears to the contrary, it is not a stranger but a so-called loved one who is most likely to assault, rape, or murder us" (p. 7).

Theories of Wife Assault

In the efforts to help family members affected by violence in the home, and also in the desire to prevent the occurrence of further violence, researchers, policy makers, and service providers have sought to understand why wife abuse is such a common phenomenon in our society. Over the years, theorists have presented their speculations and their research findings on the antecedents of wife assault. The most common theories will be presented in this section, including individual, social/psychological, and socio-cultural

theories. These theories are distinguished from one another mainly by the foci of attention, which range from the individual pathologies of the batterer and/or the victim to the broad social structures of our society.

Individual Theories

Those theorists who attempt to explain why men abuse their wives with individual theories of wife abuse focus upon factors within the batterer which predispose him to be violent. These theorists may point to the batterer's alcohol or drug abuse, to his physical or mental illness, to his neurological problems, to his psychopathology or his sociopathology as reasons for his violent behavior (Gelles & Cornell, 1990). MacLeod (1987), for example, cited studies in which researchers claim that batterers have more food allergies and lower blood sugar levels than non-batterers. Other researchers have also used individual theories to explain why women stay with their abusive husbands - stating for example that some women "have a psychological need for domination, excitement and attention" (United Nations Office at Vienna, 1989, p. 28).

Explanations for wife abuse which rely solely upon individual theories have been largely discredited in the literature. Gelles and Cornell (1990) have suggested that the individual factors described above are relevant in less than 10% of cases. However, in practice, when one hears of a particularly disturbing example of wife abuse, a common reaction is to focus upon the suspected pathologies of the individuals concerned.

Social/Psychological Theories

Those theorists adopting a social/psychological perspective look to the interaction of individual and environmental factors in explaining wife abuse. The two most common theories following this perspective are ecological theory and social learning theory.

Ecological theory focuses upon an individual's adaptive response to stress in the environment. As an explanation for wife abuse, theorists adopting this perspective focus upon the complex interaction between an individual's level of functioning, his coping abilities, his support network, and stressors such as unemployment or poverty (Gelles & Cornell, 1990). Following this approach, families at particularly high risk for wife abuse would be those in which the level of functioning of the members is low, the amount of stress in the environment is high, where there is conflict between the family members, and there is little informal or formal social support.

Bandura (1977), the originator of social learning theory, hypothesized that people learn various types of behavior through observation and modeling. Amongst social learning theorists, violence is seen as behavior which has been learned by an individual in his family of origin. From this perspective children who live in a violent family are thought to learn the beliefs that violence is a normal part of family relations; that violence is an appropriate means of resolving disagreements; that sexism is an acceptable norm; that violence in the home is not taken seriously by the community; that violence is an appropriate way of dealing with stress, and that the victims of violence not only tolerate this behavior but often are responsible for it (Jaffe, Wilson, & Wolfe, 1986c).

The widespread acceptance of social learning theory is evidenced in the treatment programs for batterers. A commonly held assumption of these programs is that batterers can learn new, non-violent ways of handling anger and conflict. According to social learning theory, it should also be possible to teach children alternatives to violence. Proponents believe that children can be taught knowledge and skills that will enable them to better cope with their environment. Jaffe et al. (1986c) suggest that children can be helped to develop adaptive thinking processes and interpersonal problem solving skills through professional intervention. These authors also propose that interventions such as perspective-taking, modeling, reinforcement, problem solving, and behavior rehearsal counteract the unhealthy behaviors that children have learned in violent families.

Socio-cultural Theories

In this group of theories, the focus of attention is on the structures of society. Some theorists focus on cultural values and norms, while others believe that violence within the home is merely an affirmation of the gender inequalities and power imbalances which characterize our social order.

Cultural theorists look to the beliefs, values, and norms of a particular culture in order to explain wife abuse. It is argued that wife abuse is likely to exist wherever there is a cultural acceptance of violence within the home. For instance, some cultures in Africa believe that the beating of a woman by a man merely demonstrates his love for her, and that if he does not beat her, she will feel rejected (United Nations Office at Vienna, 1989). Dobash and Dobash (1979) argue that societies in which wives are viewed as property of their husbands are at high risk for wife abuse.

Finally, feminist theorists view wife abuse in the context of a patriarchal society in which men have more power than women. Feminists argue that the widespread disadvantages experienced by women socially, economically, and politically are directly linked with their subjugation within the home (United Nations Office at Vienna, 1989). In other words, the fact that violence against women occurs with such frequency within the family is merely a reflection of the large scale domination of women by men. The patriarchal society encourages "a tacit acceptance by the community of abusive conduct within the home. This acceptance becomes manifest in societal attitudes that allow husbands to view their wives as chattels and that stress the privacy and autonomy of the family" (United Nations Office at Vienna, 1989, p. 31). Feminist theory is now widely discussed in the literature, and has gained acceptance among those working directly with family members affected by violence (MacLeod, 1987).

There is ongoing debate in the literature about which theories of wife assault are most valid. It is generally accepted, however, that wife abuse is a complex problem and, therefore, its causes are similarly manifold (United Nations Office at Vienna, 1989; Bidgood, Tutty,& Rothery, 1991). However, despite the complexity of the problem, as the authors of a United Nations report on wife assault state:

> ...any explanation must go beyond the individual characteristics of the man, the woman, and the family and look to the structure of relationships and the role of society in underpinning that structure...any explanation must be seen against a background of gender inequality, wherein the victim of such violence is most often the woman and the perpetrator most often the man and wherein the structures of society -

be they economic, political or legal - act to confirm this inequality (United Nations Office at Vienna, 1989, p. 33).

The Costs of Family Violence

There can be no doubt that the human, financial and social costs of family violence are very high. While one cannot quantify human tragedy and suffering, statistics, nevertheless, are suggestive of the extent to which women are damaged by abuse. Most of the women murdered in Canada were victims of their intimate partners (Jaffe et al., 1990). One in four suicide attempts by women is related to battering (Canadian Panel on Violence Against Women, 1993). A Quebec study cited in the same report found that 20% of women admitted to the hospital for emergency surgery were victims of violence. The physical injuries suffered by women across the country include broken bones, brain damage, reproductive damage, scars, black eyes, bruises, and lacerations. Furthermore, research has suggested that battered women are more vulnerable than non-battered women to psychological problems such as severe anxiety and depression (Canadian Panel on Violence Against Women, 1993).

The financial and social costs of family violence are difficult to measure, but are likely very high (Canadian Panel on Violence Against Women, 1993). These costs include the inability of the survivors to work due to physical injury or psychological problems. Wife assault results in considerable financial expenditures in areas such as health care, police services, court services, shelter services, correctional services, and counselling.

It is only recently that another cost of wife assault has been focused upon - that is, the adverse effects of this form of violence upon children. Child witnessing of wife assault includes a range of experiences:

> children may observe this violence directly by seeing their father (or another intimate partner of their mother) threaten or hit their mother. They may overhear this behavior from another part of their residence, such as their own bedroom. Children may be exposed to the results of this violence without hearing or seeing the commission of any aggressive act. For example, children may see the bruises or other injuries clearly visible on their mother or the emotional consequences of fear, hurt, and intimidation that may be very apparent to them (Jaffe et al., 1990, p.17).

Child witnessing of violence is common. In a Quebec study of violence within the home, three quarters of the women's children were present for episodes of battering (Canadian Panel on Violence Against Women, 1993). Leighton (1989, cited in Jaffe et al., 1990) reported that children were present in 68% of 2910 wife assault cases in an Ontario research project. Carlson, an American researcher, estimated that 3.3 million children in the United States are yearly at risk of exposure to parental violence (cited in Jaffe et al., 1990).

In sum, the costs of wife assault are obviously high, and include the murders of women, physical and psychological damage to the survivors, high financial and social costs to society, and finally, adverse effects upon the children who witness the violence.

The Effects upon Children of Witnessing Wife Assault

A knowledge of the cognitive and social development of children is essential in order to understand how children interpret their witnessing of interparental violence (Ragg, 1991; Jaffe et al., 1986c), and in turn, how the violence affects them. A developmental perspective leads one to focus on "the sequential, unfolding intellectual, personality, and behavior changes that occur during childhood and the factors that influences these changes" (Gander & Gardiner, 1981). Developmental theorists such as Piaget, Kohlberg, Erikson and Havighurst (cited in Gander & Gardiner, 1981) have outlined various stages through which normal children proceed as they grow and develop. According to Piaget, "children interpret experience consistent with their present conceptual organization" (cited in Gander & Gardiner, 1981, p. 211). For instance, Piaget has theorized that preschool children are normally in the stage of pre-operational thought. One characteristic of this stage is 'centration' - the ability to process only a limited amount of information at one time, or the centering of one's attention on only one feature of a task (Gander & Gardiner, 1981). In regard to children's witnessing of violence, this 'centration' means that :

> preschool children must rely on parents and other adults to understand and interpret the full situation. This dependency extends to all areas of living and includes nurturing, problem solving and safety needs which results in significant vulnerability for the child living in a violent home...(engendering) insecurity and anxiety within the child (Ragg, 1991, p. 61).

Another characteristic of the pre-operational stage is egocentricity - the propensity to see oneself as the 'centre of the universe' (Gander & Gardiner, 1981). Egocentricity can also be problematic for children in violent homes:

> children's ego-centric thinking, combined with their ideas of absolute cause-effect relationships and the inability to incorporate more than one variable at a time into their thinking, makes it logical for them to believe they caused the violence and can control it (Davis, 1988, p. 299).

A complete discussion of the theories of child development is beyond the scope of the present study. The salient point, however, is that the processes by which children are affected by family violence can best be understood by taking into consideration the unique characteristics of the particular developmental stage currently experienced by the child.

Children are adversely affected by family violence in three major ways. Firstly, they are at high risk of being abused themselves if their mother is being victimized by her intimate partner (Layzer, Goodson & Delange,1986; Roy, 1988; Jaffe et al., 1990). Secondly, witnessing their mothers being assaulted is traumatic for children, and they often experience psychological and behavioral problems as a result. Thirdly, growing up in families where their mothers are assaulted may adversely affect children's beliefs about who is responsible for the violence, as well as their knowledge of safety skills strategies. The remainder of this section will address these three points in detail.

Risk of Physical Abuse

Children of battered women appear to be at risk of being physically abused in the family. Layzer et al. (1986) found that 70% of the child

witnesses in their sample were victims of either physical abuse or neglect. Similarly, Bowker, Arbitell, and McFerron (1988) stated that male batterers abused children in 70% of the families in their sample where children were present. Gibson and Gutierrez (1991) reported that 23% of their sample of 81 child witnesses had been physically abused, while Wildin, Williamson and Wilson (1991) found that roughly two-thirds of the battered women in their study reported that their children had also been victims of physical abuse. Jaffe, Wolfe, Wilson and Zak (1986b) noted that the overlap between physical abuse and witnessing of violence is generally believed to occur in about 40% of cases.

Research has suggested that child witnesses who are also abused themselves are subject to a "double whammy" in terms of the psychological and social effects such violence has upon them. In other words, the problems of abused witnesses appear to be even more pronounced than those of non-abused witnesses. Davis and Carlson (1987), for instance, found in comparing a sample of abused witnesses with non-abused witnesses, that 88% of the sample of abused children displayed behavior problems which fell within a clinical range, while 47% of the non-abused witnesses fell within this clinical category. Hughes (1988) studied three groups of children - abused child witnesses of parental violence residing in a shelter, non-abused child witnesses residing in a shelter, and a comparison group of children from a similar economic background but from nonviolent families. In a comparison of general distress levels, she found that the abused-witness children were the most distressed. The distress levels of non-abused witnesses fell between the levels of those from nonviolent homes and the abused children.

While research has provided evidence that children who witness violence are at a higher risk of having been physically abused, some authors have recently speculated that they may be at a similar risk of sexual abuse. Kenning, Merchant, and Tomkins (1991) stated that the possible association between child sexual abuse and the witnessing of violence needs to be further explored in research. To date, no studies have been conducted which indicate that children who are witnesses of violence are also at a higher risk of being sexually abused. However, neither have there been studies specifically designed to investigate this issue. Finkelhor and Baron (1986) outlined several risk factors for child sexual abuse, which include a) parents in conflict, b) a poor relationship with parents, c) mother disabled or ill, and d) ever having lived without the natural father. Given that these factors are present in the experiences of many child witnesses, it seems theoretically possible that child witnesses may also be at an increased risk of sexual abuse.

Psychological and Behavioral Effects of Witnessing Violence

Much of the early literature on the adverse psychological and behavioral effects of conjugal violence upon children is based upon anecdotal reports from shelter staff and other professionals whose work exposed them to children from violent homes. More recent research, however, has contributed empirical data to the knowledge base, and this research has supported the previous observations. There is general agreement that children suffer detrimental consequences from witnessing parental violence. The following section will discuss these consequences, including internalizing and externalizing behavior problems, post-traumatic stress symptoms, and decreased social competency.

Internalizing problems.

Children who witness conjugal violence are more likely than children from nonviolent homes to display internalizing problems such as depression, withdrawal, and anxiety. Jaffe et al. (1986a) found that both male and female children from violent families were reported by their mothers as displaying significantly more internalizing behavior problems relating to depression and anxiety than the comparison group of children from nonviolent families. Davis and Carlson (1987) reported that 53% of their sample of child witnesses scored in the clinical ranges on a measure of depression. These researchers noted age differences with the female children - 71% of the scores of the school-aged girls fell within the clinical range, compared to 13% of the scores of preschoolers.

Hughes (1988) made comparisons between child witnesses who had been abused with non-abused child witnesses, and a comparison group of children from non-violent homes. She found that both the abused witness and the non-abused witness children scored significantly higher than the comparison group of children on a child-reported anxiety measure. Reporting on their observations of children at a shelter, Alessi and Hearn (1984) noted that, "the children exhibit a high degree of anxiety - biting their fingernails, pulling their hair, and somaticizing feelings as manifested by complaints of headaches and "tight" stomachs". In another study of shelter children, Hughes (cited in Jaffe et al., 1990) found that 55% of the sample were severely withdrawn.

There has been little empirical research investigating the extent to which child witnesses of wife assault suffer from poor self-esteem, and the few studies which have been conducted have contradictory results. For instance, Hughes and Barad (1983) found that the average self-esteem scores of grade

1-7 child witnesses were within the normal range. However, these researchers did report that the preschool group in their sample scored below average on the self-concept measure. In the study previously described, in which Hughes (1988) compared abused witnesses with non-abused witnesses and children from non-violent homes, some of the child witnesses scored significantly lower on the measures of self-esteem than the comparison group of children. The 9-12 year old abused witnesses scored signficantly lower than the comparison group, and the differences between the non-abused witnesses and the comparison group approached significance ($p < .06$). Both groups of 6-8 year old child witnesses in her study scored significantly lower on the self-esteem scales than the comparison group of children.

Finally, from their review of the research, Jaffe et al.(1990) concluded that while both female and male child witnesses experience greater levels of internalizing problems than children from non-violent homes, girls from violent homes tend to have greater internalizing problems than boys.

Externalizing problems.

Child witnesses seem to experience a higher degree of externalizing behavior problems such as aggression, hyperactivity, and delinquency than children from nonviolent homes. Jaffe et al. (1986a) found that the male child witnesses in their sample were reported as displaying a significantly higher degree of externalizing symptoms than the comparison group of boys. However, female child witnesses were not significantly different on this measure than girls from nonviolent families. Davis and Carlson (1987) found that the scores of 70% of their sample of child witnesses were in the clinical range in terms of behavior problems. These researchers noted some gender and

age differences, reporting that the scores of 70% of preschool boys versus 53% of school-aged boys fell within clinical ranges on this variable. Sixty percent of female preschoolers fell within clinical ranges, while 88% of school aged girls were in the clinical category of behavior problems. This latter statistic is interesting, in that, in contrast to the research of Jaffe et al.(1986a), it highlights that externalizing problems may be experienced by school-aged girls. Davis and Carlson (1987) concluded that, "while the majority of boys and girls in both age groups were in the clinical range in total behavior problems...those most affected are the preschool boys and the school-aged girls" (p. 288). Similarly, Hershorn and Rosenbaum (1985) found that parental marital discord and violence are associated with conduct problems in witnessing children.

Davis and Carlson (1987) noted that 40% of their sample of child witnesses fell within clinical ranges on measures of aggression. Interestingly, they found that school-aged girls had significantly more problems with aggression than school-aged boys. Male preschoolers, however, had more aggressive tendencies than their female peers.

Fantuzzo, DePaola, Lambert, Martino, Anderson and Sutton (1991) reported that both shelter preschoolers and preschoolers living at home with violent parents exhibited levels of externalizing behavior problems which fell within the clinical ranges. These levels were assessed as being significantly more severe than their counterparts in nonphysically violent homes.

Post-traumatic stress symptoms.

Post-traumatic stress refers to the reactions of individuals who witness or directly experience life-threatening events (Arroya & Eth, 1995). There are

two types of post-traumatic stress, one of which occurs in the aftermath of an isolated, but very disturbing, incident. The second, more serious type, occurs when an individual is repeatedly exposed to traumatic events. Furthermore, Silvern, Karyl, and Landis (1995) point out that it is especially distressing for the witnesses or victims when the danger arises from the human action of a familiar person, in an environment which one expects to be safe. These authors noted that, "such conditions profoundly violate expectations about the safety and goodness of the world" (p. 44). Clearly, the latter, most serious form of psychic trauma is applicable to child witnesses of violence whose mothers are the targets of constant, often extreme, physical abuse. Children in this situation may experience a high degree of fear, helplessness, and overstimulation (Silvern & Kaersvang, 1989), and their symptoms of post-traumatic stress represent their attempts to cope with such overwhelming circumstances. These symptoms may include "massive denial, repression, dissociation, self-anesthesia, self-hypnosis, identification with the aggressor, and aggression turned against the self" (Terr, cited in Arroya & Eth, 1995). Developmental delay, developmental regression, conduct disorders, and internalizing problems are also associated with such psychic trauma (Silvern & Kaersvang, 1989; Arroyo & Eth, 1995).

Empirical research has supported the presence of post-traumatic stress symptomatology among child witnesses. For example, children who witness the murder or rape of their mothers exhibit substantial evidence of psychic trauma (Malmquist, 1986; Pynoos & Eth, 1984, 1986; Pynoos & Nader, 1988; cited in Silvern et al., 1995). In another small study, half of a sample of 20 child witnesses residing at a women's shelter reported "severe" post-traumatic stress disorder (Landis, 1989; Silvern, Landis, & Karyl, 1990; cited in Silvern et

al., 1995). Silvern and her colleagues (in press, cited in Silvern et al., 1995) also found in a retrospective study of university students that "reports of parental spouse abuse were associated with high levels of current, adult post-traumatic symptoms", suggesting that such symptoms may also extend into adulthood. Jaffe and his colleagues (1990) concluded, on the basis of clinical and empirical data, that "children exposed to wife abuse may be similar to those children described as suffering from posttraumatic stress disorder" (p.72).

Social competency.

Some researchers have found that child witnesses score low on measures of social competence. For example, Jaffe et al. (1986a) found that girls and boys who had been exposed to parental violence scored lower on measures of social competence than did a comparison groups of children from nonviolent homes. Davis and Carlson (1987) studied children who had all been exposed to parental violence. They reported that 32% of the preschoolers and 27% of the school aged children scored in the clinical ranges in social competence. They noted that age differences showed up with the females - 47% of the scores of school-aged girls fell within the clinical range, while only 7% of female preschoolers were in the clinical category.

Similarly, Fantuzzo, DePaola, Lambert, Martino, Anderson and Sutton (1991) suggest that preschoolers' capacities for empathy and social skill development are disrupted by family violence. A group of shelter preschoolers who were exposed to both verbal and physical violence, as well as the stress of shelter residency, displayed the lowest levels of social competency compared with two other groups of children who either witnessed verbal conflict only, or verbal plus physical conflict. This unique strategy of comparing shelter

children with children who witness violence but remain at home, highlights the additional problems experienced by child witnesses who are also shelter residents.

Rosenberg (cited in Jaffe et al, 1990) focused upon the social problem solving abilities of child witnesses of violence, and found that child witnesses were more likely than their non-witnessing counterparts to choose passive or aggressive problem-solving techniques rather than assertive ones.

Finally, it is important to note that not all researchers have found differences in social competence between child witnesses of violence and children from non-violent homes (Cassady, Allen, Lyon, & McGeehan, 1987; cited in Jaffe et al, 1990), suggesting the need for continued research in this area.

Child Witnesses' Beliefs and Knowledge about Wife Assault

Assigning responsibility for the violence.

Jaffe et al.(1990) stated that one of the effects of witnessing violence is that children may, "accept an exaggerated sense of responsibility for the violence in their family" (p. 53). Developmental theories, described previously, provide one explanation for the readiness with which children assume responsibility for the violence themselves, and for their accompanying feelings of guilt.

In general, couples in violent relationships tend to be characterized by "an inability to accept responsibility for one's own thoughts, feelings, and actions" (Elbow, 1982, p. 466). The abuser frequently blames the victim for his behavior, and the victim accepts the blame. Children are also vulnerable to becoming involved in this blame pattern, and may believe that if only mother

would 'do things better', father would not have cause to be so angry and violent.

The results of such beliefs are that the responsibility for the abuse is deflected from the batterer onto the victims. In terms of the implications for female children, Jaffe et al. (1990) stated that, "one can speculate about how this view may be the early seeds for their own future victimization in marriage" (p. 52).

Knowledge and skills in dealing with violent incidents.

Another somewhat surprising effect of witnessing violence is that child witnesses typically have less knowledge or skills in dealing with violent situations than children from non-violent homes (Jaffe,Wilson & Wolfe, 1988). Jaffe et al.(1988) stated that the child witnesses, "presented themselves as lacking basic skills on what to do in an emergency situation. This finding is especially alarming since many of these children will have to face ongoing crises in their lives that will involve their personal safety" (p. 161). In some cases, children may know what to do to get help, but because they have been previously frustrated trying to get help, they feel a sense of hopelessness. In other cases, children resist taking action because they have divided loyalties between their mother and their father (Jaffe et al., 1990).

Summary

Wife assault is a widespread, pervasive problem in our society. The consequences of this form of violence are often tragic, resulting in the death, physical injury, and psychological impairment of women. Theorists have provided explanations for the occurrence of violence in the family, however,

"the collected scholarship that seeks to explain violence against women in the home indicates that the explanation is complex and certainly multi-factorial" (United Nations Office at Vienna, 1989, p. 33).

There appears to be little doubt that witnessing their mothers being physically, sexually, and/or emotionally abused is harmful to children. Research has reported that children are adversely affected in a number of ways. Child witnesses are frequently victims of child physical abuse and neglect themselves, which serves to intensify their adjustment difficulties. This finding suggests that future research investigating the effects of violence upon children should try, if possible, to distinguish between abused and non-abused child witnesses. It is also possible that child witnesses are at a higher risk of being sexually abused, although little research has been conducted to explore this hypothesis. Child witnesses show evidence of both internalizing and externalizing behavior problems, and appear to be less socially competent. Children who repeatedly witness their mothers being abused may experience symptoms of post-traumatic stress disorder. Children frequently experience more subtle effects of witnessing violence, which include distorted and ingrained beliefs about who is responsible for the violence in their home, and may exhibit a lack of knowledge and skills in dealing with violent situations.

It also seems clear from the literature that age and gender variables may have an important bearing on the effects of witnessing violence upon children. To date, the literature has highlighted the problems experienced by preschool children. It is important to note, however, that these findings present a dilemma. It is not necessarily the case that preschoolers are more affected by family violence than other children, it may simply be that since preschoolers express their feelings predominantly through their behavior,

measurement instruments which gauge the psychological adjustment of children by assessing behavior will highlight the problems of preschoolers. Several researchers have also found gender to be an important variable mediating the effects of family violence, although some of the outcomes have been contradictory. For instance, Jaffe et al. (1986a) found that boys are more likely to experience externalizing behavioral symptoms than girls, while Davis and Carlson (1987) found that school-aged girls were at a higher risk of developing behavior problems than school-aged boys. It would be safe to conclude that in future research, age and gender are variables which should be examined in relation to the effects upon children of witnessing violence.

In sum, violence against wives is surely a social problem of great magnitude, with high personal, social and economic costs. Children are the unintended victims of such violence, as a shelter worker poignantly stated:

> These children really are the innocent victims of a major war being fought in many battles across the country. These kids are prisoners of that war. They are trapped in the actual violence while they are little and can't get out on their own, and they may be trapped in it psychologically for the rest of their lives. We've got to get amnesty for these children (MacLeod, 1987, p. 70).

CHAPTER TWO
INTERVENTION

Ideally, interventions with children who witness wife assault should coincide with interventions aimed at helping fathers to take responsibility for their abusive behavior, and with appropriate counselling programs for mothers (Jaffe et al., 1990). Unfortunately, however, in many cases, parents are often unwilling or unable to attend counselling themselves. In such cases, the goals of intervention need to focus upon helping children to protect themselves from physical danger, and on helping to lessen the impact of the violence upon them. Jaffe et al. (1990) note that, "this goal represents a challenge analogous to 'being sane in insane places' as the child has to avoid responsibility for violence and learn not to imitate repeated aggressive acts" (p. 84).

The first priority for any helping professional who is working with a child witness of wife assault must be to ensure the safety of the child. Clearly, until the child is safe, he or she will not be ready to address emotional issues or behavioral changes in counselling (Jaffe et al., 1990). Secondly, in writing about children who witness violence in their homes, many authors emphasize the need for immediate intervention in order to help children to talk about the details of the trauma experienced and to express their feelings (Carlson, 1984; Silvern & Kaersvang, 1989). Carlson (1984) states that regardless of whether the treatment occurs on an individual or a group basis, it is essential that the focus be on the children's emotional reactions to what is happening in their families. Children, Carlson (1984) contends, benefit from identifying and expressing their feelings. Jaffe et al. (1990) note that the children they have interviewed in their research, "are almost universal in their need to be listened

to, believed, and supported. They usually are not looking for solutions but an opportunity to share their fears about their mother and perhaps all members of the family" (p. 83). Furthermore, professionals need to be especially skillful and sensitive in attending to children, since, as previously discussed, the norm in many violent families is to keep the abuse a secret (Silvern & Kaersvang, 1989). In order to facilitate such emotional expression and release, it is important that counsellors allow children ample time to develop a level of trust and comfort with them (Jaffe et al. 1990).

This chapter describes various modes of intervention with child witnesses of wife assault. The most common intervention strategy suggested by authors is group counselling (Jaffe et al., 1990); this is also the type of program which has been most frequently evaluated in the literature. Individual play therapy has been recommended by a number of authors, particularly for children who have been severely traumatized by the violence in their families (Jaffe et al., 1990; Arroyo & Eth, 1995; Silvern et al., 1995) . Further, since in many cases of wife assault, families do reunite or remain intact, some authors have advocated a family therapy approach. Finally, others have described educational prevention programs, in which efforts are made to prevent family violence from occurring, by conducting family violence awareness programs in the schools.

Group Counselling

Shelter-based Group Counselling

Many children who witness wife assault first come to the attention of professionals when the families seek refuge in women's shelters. These children are usually in crisis, having witnessed their father assault their

mother, and having been uprooted from their home, their friends, and their belongings. From a professional standpoint, such a crisis can represent an opportunity to help children and their families, since often this is when people are most open to receiving assistance. In recent years, many shelters have developed programs to assist the children of battered women:

> one of the most profound changes in the last seven years in service delivery is the growth of concern and program development for the children of battered women...Increasingly, it is being recognized that the problems of the children **are** the problems of the mother. It is also widely acknowledge that we must look to prevention, and so to the children of battered women, if we want to help reduce the number of battered women in the future (MacLeod, 1987, p. 69)

Services provided to children in shelters have included recreational activities, developmental, psychological, and medical screening, advocacy, individual counselling and group counselling (Layzer et al, 1986; Hughes, 1982; Alessi & Hearn, 1984; Gibson & Gutierrez, 1991). The shelter setting presents some unique challenges to those providing children's services, including a clientele who are very transient, a wide age range of children, and a limited availability of staff to provide interventions. Alessi and Hearn (1984) argue that a group approach can successfully overcome some of these obstacles, firstly because group counselling is more efficient than individual counselling, and secondly, because it provides opportunities for peer support. Jaffe et al. (1990) note that, "groups allow children an opportunity to learn that they are not alone in dealing with their trauma and that other children have comparable life experiences. Children can learn helpful coping strategies from other 'survivors' and caring adults who lead the group" (p. 87). Thirdly, to address the

problems associated with a transient population, Alessi and Hearn (1984) propose a highly structured, time limited, intensive group model for children 8 - 16 years old. Other authors in the literature have also supported the value of the group approach in shelters (Layzer et al, 1986; Hughes, 1982; Gibson & Gutierrez, 1991).

In terms of the specific nature of these shelter-based groups, topics have included the identification and expression of feelings (Layzer et al., 1986; Hughes, 1982; Alessi & Hearn, 1984; Gibson & Gutierrez, 1991), non-violent ways of getting one's needs met (Layzer et al, 1986, Hughes, 1982, Alessi & Hearn, 1984), new strategies for problem-solving (Gibson & Gutierrez, 1991; Alessi & Hearn, 1984), coping with change and transitions (Hughes, 1982; Alessi & Hearn, 1984), feelings about father (Hughes, 1982), and sex, love, and sexuality (Alessi & Hearn, 1984). An overall goal shared by two such programs was to offer support to the children and mothers in the emergency shelter and help them to resolve their current crisis (Alessi & Hearn, 1984; Hughes, 1982).

Two unique approaches with shelter children were discussed in the literature. Firstly, Rhodes and Zelman (1986) provided a multifamily group in a shelter, based upon the assumption that people in crisis feel isolated and alienated. The rationale for including the mothers and the children together in the group was that they would be better able to support one another through the crisis, and also that since the children were often missing their fathers, the need for their mothers increased. The goal of this twice-weekly group was to strengthen the capacities of mothers and children to cope with issues of domestic violence, separation and loss, the current crisis and associated stressors, parent and child issues, and ambivalence toward the shelter.

Secondly, Kates and Pepler (1989) reported on a reception classroom which was held for school-aged children in shelters. This classroom was set up to meet both the academic and emotional needs of child witnesses. Social and emotional programming included individual, on-the-spot counselling, informal group discussions, social skills training, and joint efforts between the shelter and classroom staff in supporting the children and mothers. None of the above groups were formally evaluated. However, some evaluative comments were included in the researchers' reports. Rhodes and Zelman (1986), for instance, stated that:

> the group proved useful in strengthening mutually supportive aspects of parent-child functioning in a period of crisis, enhancing cohesiveness and mental support among families at the shelter, enabling clients to benefit from the supportive aspects of the shelter by reducing their ambivalence toward it, and assessing the ongoing mental health needs of the children and their mothers (p. 130).

Hughes (1982) stated that the staff involved with the shelter-based group counselling program felt that the program was very beneficial to the children. Layzer et al. (1986) obtained follow-up data on 112 children who participated in their program. While no attempt was made to evaluate the effectiveness of the children's program, they did find that the major factor determining whether violence continued in the children's lives was whether or not the mother returned to the batterer. In almost all cases where the mother had left the partner, the children ceased to be the objects of physical violence.

Community-based Group Counselling

In general, the short-term, community-based groups for child witnesses outlined in the literature share common characteristics. Groups are conducted on a weekly basis for approximately ten weeks, and attempt to address the salient behavioral, emotional, and cognitive issues associated with witnessing parental violence (Jaffe et al., 1990; Ragg, 1991). Referrals for the groups typically come from women's shelters, children's mental health facilities, or child protection agencies (Jaffe et al., 1990). Several authors have written articles describing, but not evaluating, their particular models of group intervention with child witnesses. These will be described, followed by the published studies that evaluated community-based groups for child witnesses.

Ragg (1991) noted that while a general trend has been to provide similar programs to children of all ages (i.e. 6-12 years old), several authors (Jaffe et al., 1986c; Ragg, 1991; Tutty & Wagar, 1994) argue that it is essential to tailor the groups according to the developmental stages of children. Ragg (1991) described his "differential group approach", in which the techniques, content, and goals of the group vary according to the age of the child. The developmental categories within Ragg's model include the preschool child (ages 3-5), the school age child (ages 6-8), the latency age child (ages 8-10), the young adolescent (ages 11-13), and the adolescent child (ages 13-16).

Tutty and Wagar (1994) stated that, "groups for younger children must be structured differently from groups for latency-aged children (because) developmentally, younger children are less likely to be able to articulate their experiences and needs" (p. 93). They described a unique program entitled "The Storybook Club" in which 5-7 year old child witnesses are encouraged to relate their own experiences and feelings through story-telling and drama.

Frey-Angel (1989) outlined a sibling group approach to treating child witnesses. She noted several advantages of this approach, including the following. First, the groups can incorporate children of varying ages in the same group - Frey-Angel suggested that children as far apart in ages as 3 and 12 can attend the same group. She noted that younger children can be especially helpful in challenging the defenses of older children, since youngsters often disclose events quite readily. Secondly, it is an advantage that siblings have a history in common, that they will be together long after the group has dispersed, and that there is a higher potential for trust to develop within these relationships. Thirdly, Frey-Angel noted that treatment groups, by their very nature, call into question the values of the parents. This can be very threatening for children. However, sibling groups, with their potential for mutual support, can help to counter the fear associated with challenging values. Fourthly, since real sibling conflicts may be acted out within the group, the leaders are presented with a unique opportunity to actively intervene to teach new ways of relating to one another. Finally, Frey-Angel pointed out that one of the main advantages of a group format is that it enables children to see that they are not alone in the problem of family violence; they can see that others are going through similar experiences with their own parents.

Several researchers have evaluated these short-term groups for child witnesses of wife assault. Peled and Edleson's (1992) qualitative evaluation of a group counselling program for 4-12 year old child witnesses provided some interesting and in-depth data on the intended as well as unintended results of the program. The goals of this group were to "break the secret" of family violence, to teach children how to protect themselves, to provide a positive experience for the children, and to strengthen their self-esteem. While the

researchers were careful to point out that the results of their qualitative investigation are not generalizable, they did find that the goals of the group were achieved. They also discovered that the group had some unintended outcomes for the participants.

"Breaking the secret" of wife abuse is important if children are to overcome the feelings of shame, guilt, and isolation commonly associated with family violence (Peled & Edleson, 1992). In this regard, the researchers reported that upon completion of the group, most of the 30 children in the sample were able to define abuse, to label different forms of abuse, and to make judgments that abuse was not acceptable. Secondly, the authors stated that ,"a gradual process of emotional disclosure and learning to talk about feelings was evident for all the children in the group" (p. 333). This expression of emotion was experienced by children both as a relief and as a source of stress, since they were releasing pent-up feelings but also giving up defenses which had formerly been in place to protect themselves. The researchers also noted that often the children were relieved to discover that their family was not the only one experiencing violence, and to find out that some situations were worse than their own. Finally, while Peled and Edleson (1992) acknowledged that not all children of battered women take responsibility for the violence themselves in the first place, they stated that for those who do, "the burden of guilt may be somewhat relieved by realizing that the violence was not their fault"(p. 333). Interviews with the children and the mothers after the end of the group revealed that, in general, children did not feel responsible for the violence in their families.

Some of the unintended consequences of the group in relation to "breaking the secret" were that children would sometimes use their new

knowledge of abuse to point out abusive behavior in their parents. Some parents reacted to this positively, but as one can imagine, others felt threatened and reacted negatively. It was also, at times, a difficult process for children to place the responsibility for the violence on the abuser.

It seemed that the group did help children to learn how to protect themselves from further emotional, physical and sexual abuse. The researchers reported that children remembered their "protection plan" several months after the termination of the group. Another aspect of learning to protect oneself involved the use of assertive communication. Both children and parents described improvements in this regard. However, another unintended result of teaching assertiveness was that in some cases this may have put children at risk for further abuse if there was a parental norm dictating against self-assertion.

The researchers reported that although most children were initially resistant to attending the group, they came to enjoy and look forward to the group each week. They experienced the group as an enjoyable and fun activity. Most children also reached a stage at some point in the program where they began to feel safe and comfortable.

Peled and Edleson (1992) hypothesized that the attainment of the previous three goals helped to strengthen the children's self-esteem. While the process of "breaking the secret" was often a painful one, the sharing of experiences with others helped the participants to feel less alone in their problems, to shed some of their feelings of shame and guilt, and, ultimately, to feel better about themselves. Learning to protect oneself is, by itself, an empowering, self-affirming process. Finally, because the groups were fun for the children, "a positive experience for the children in group meant a positive

experience of themselves. They learned they could be respected and cared for, and, thus, to be part of a positive, enjoyable interaction" (p. 339).

The programs which have been evaluated with quantitative methodology are similar in nature to the group described by Peled and Edleson (1992). The intervention model studied by Jaffe et al. (1988) is designed to help child witnesses to:

> develop adaptive responses to experiences they have already encountered, learn effective and safe problem-solving techniques to confront future difficulties, focus on attitudes toward relationships and responsibility for behavior, examine the use of violence as an effective method for resolving conflict, and develop self-esteem (p. 181).

Jaffe et al. (1988) were careful to point out that the group is not intended for children in crisis, such as the shelter population. Specific topics covered in the community-based groups include labeling feelings, dealing with anger, safety skills, social support, social competence, self-concept, responsibility for parents, responsibility for violence, understanding family violence, and issues related to separation and divorce. The groups were divided into two age groups: a) 7-10 years, and b) 11-13 years. Wagar's (1991) program in Calgary was structured similarly to Jaffe's (1988). Grusznski, Brink and Edleson (1988) reported on the findings from a children's program in the American "Domestic Abuse Project". This is another ten week program, with the following content: 1) establishing responsibility for the violence 2) issues of shame and isolation 3) protection planning 4) expression of feelings 5) conflict resolution 6) gender role issues 7) building self-esteem, and 8) discussion of sexual abuse.

Evaluations conducted on each of these groups indicated that some positive results were associated with the group intervention. Jaffe et al. (1988) used a pre-test, post-test research design to assess the impact of their program. Although they found no statistically significant changes in child behavior using the Child Behavior Checklist (Achenbach & Edelbrock, cited in Jaffe et al., 1990) as a measurement tool, they did find that the children a) reported significantly more safety skill strategies and b) a more positive perception of their mothers and their fathers after the group. No differences were found in the degree of responsibility that children assumed for the violence between their parents - in fact, it was discovered that both the comparison and the treatment groups indicated feelings of responsibility for their parents. Jaffe et al. (1990) reported that the group program seemed to be most effective for children with mild to moderate behavioral problems. Children who had been repeatedly exposed to severe violence appeared to have benefited only marginally from the intervention. As previously mentioned, Jaffe et al.(1990) suggested that these children require more intensive, individual therapy.

In evaluating her group for child witnesses, Wagar (1991) used a stronger research design that included random assignment and a waiting list control group. The children in the treatment group showed statistically significantly greater changes than the control group in their attitudes and responses to anger, as well as in their knowledge of support and safety skills. Similar to research results of Jaffe and his colleagues (1988), the group program was not associated with a significant change in the children's sense of responsibility for their parents or for the violence. The children's scores in both

the experimental and control groups indicated that both groups of children felt a high degree of responsibility for their parents.

In order to evaluate their program, Grusznski and colleagues (1988) had the group leaders complete clinical rating scales for 371 children who attended group counselling. The rating scales indicated the number of children who met each of four general program goals. The results suggested that the program was successful in terms of a) helping children to both acknowledge the reality of violence in their families and also realize that the violence was not their fault, b) increasing the self-esteem of the children, c) teaching the children new methods for self-protection and a knowledge of both formal and informal resources they could use and d) teaching new, nonviolent means for solving problems.

Children who have been abused themselves in addition to witnessing parental violence may need special treatment consideration. Some researchers have speculated that abused children may be reluctant to share openly in a group designed for child witnesses, as they may sense that they are alone in their experiences (Peled & Edleson, 1992). In addition, as previously outlined, abused witnesses seem to suffer more detrimental effects than non-abused witnesses (Hughes, 1988; Davis & Carlson, 1987). Peled and Edleson (1992) suggested that perhaps separate groups should be formed for abused witnesses, or at least the leaders should ensure that the group is comprised of several children who have been subjected to abuse as well as the witnessing of violence.

Individual Psychotherapy

Some authors advocate individual counselling for child witnesses, arguing that the symptoms of post-traumatic stress disorder, frequently observed in these children, are best addressed through individual psychotherapy (Arroyo & Eth, 1995; Silvern et al., 1995). Jaffe et al. (1990) suggested that individual counselling may be necessary for children who have been repeatedly exposed to severe acts of violence over many years. However, Silvern and her colleagues (1995) stated that, in practice, children of battered women are unlikely to receive individual therapy for their witnessing of violence unless they display troublesome, manifest symptoms, in which case they are likely to receive therapy outside the context of the violence. These researchers caution that if children's symptoms are treated without addressing the witnessing of wife assault, such therapy "can be ineffective or even harmful" (p. 72).

The various models of individual psychotherapy with trauma survivors share some common assumptions. First, it is accepted that individuals experience distress after witnessing traumatic events and second, that symptoms arise from this distress. Some post-traumatic symptoms, such as hyperarousal and feelings of re-experiencing the trauma, are seen as direct expressions of this distress, while other symptoms such as dissociation, withdrawal, and avoidance-type behaviors are viewed as defenses against the distress (Silvern et al., 1995). Defenses and distress form a "self-sustaining, vicious circle" (p. 50) because as long as the distress continues, the individual's defenses are deployed. At the same time, the defenses prevent the individual from coming to terms with the traumatic event. Depending upon the types of symptoms, then, the strategies in individual therapy are to alleviate a child's

distress following exposure to witnessing violence, and/or to weaken the defenses (Silvern et al., 1995). The goal of therapy is "to interrupt the vicious circle between defense and distress" (p.50).

Silvern and her colleagues (1995) provided a case study of the effectiveness of psychotherapy with a child witness of violence, and suggest that there is an "urgent need to develop and test treatments for children of abused women" (p. 72). They strongly advocate the inclusion of individual psychotherapy among treatment alternatives.

Family Systems Intervention

Parental Intervention

Many authors agree that in order to help children most effectively, interventions should include other members of their family (Jaffe et al. 1986c; Silvern & Kaersvang, 1989; Moore, Pepler, Mae, & Kates, 1989). Tutty and Wagar (1994) state that "a systems perspective is critical whenever one is offering intervention with children" (p. 101). These authors describe the efforts they made to work concurrently with the parents of children in their counselling groups - including home interviews and a parent support group which was held at the same time as the children's groups. Peled and Edleson (1992) noted that the children in their group counselling program learned to express pent-up feelings and increased their assertiveness. However, because of the potential risk to children that occurs with this emotional expression, they assert that "child participation in groups should be contingent on parent involvement in a similar adult program" (Peled & Edleson, 1992). They also emphasize the importance of open, ongoing communication between the group leaders and the parents.

Family Therapy

There are few articles written on family therapy approaches for families in which wife assault is the presenting problem. The direct application of family systems theory to cases of family violence has been criticized in feminist circles, because of the tendency for victims to be blamed for having provoked the violence (Hurley & Jaffe, 1990). However, two articles in which family interventions are recommended for this problem will be discussed in this section (Gentry & Eaddy, 1980; Hurley & Jaffe, 1990). Hurley and Jaffe (1990) provided a rationale for family therapy, arguing that "there is an urgent need to work on the effects of violence for families who stay together" (p. 474), however they were careful to point out that therapists must familiarize themselves with feminist theories of family violence, in order to ensure that the therapy process does not support a patriarchal ideology and further oppress women.

Gentry and Eaddy (1980) defined spouse abuse as a family problem, and argue on the basis of systems theory that if change is made in only one part of the family system, other members will, "act to sabotage changes in order to maintain the present state, even if it is dysfunctional" (p.242). They, therefore, suggest that "total family treatment and open system interventions" are more likely to be successful than "victim protected and closed system approaches" (p. 242).

The treatment plan described by Gentry and Eaddy (1980) attempted to ensure the safety of all of the family members, and it established the goals of treatment. Interventions were then tailored to the family's goals, but were often focused, in the case of adults, upon practicing alternative, non-violent

behaviors. In the case of children, the interventions were aimed at increasing their self-esteem. Depending upon the particular needs of each family, treatment took place with the family as a total unit, or with various combinations of family members.

Hurley and Jaffe (1990) took a cautious approach in recommending family therapy in cases of family violence, warning that in such interventions, the violence must be seen as the primary issue in the family. They stated that, "the family therapist must guard against the tendency to reframe the presenting problem as the logical outcome of underlying processes in the family" (p. 474). Viewing violence from an interactional perspective should not imply that all members are equally responsible for the violence, nor should this perspective lend any support to the mistaken notion that family members may 'provoke' the violence (Hurley & Jaffe, 1990).

These authors delineated the special precautions that must be taken when working with violent families, distinguishing between "first phase" and "second phase" interventions. The purpose of "first phase" interventions is to provide protection from the violence for women and the children, and to ensure that those carrying out violent acts take responsibility for such actions. "First phase" interventions include shelter residency for the women and children, support and empowerment for women as individuals in their own right, advocacy work with both women and children, and legal interventions. Interventions with men in this first phase most often consist of group counselling in a batterer's group.

According to Hurley and Jaffe (1990), family therapy is a 'second phase' intervention which should be considered only in cases where the man has renounced his violent behavior, where he is actively working on nonviolent

ways of expressing anger, and where the issues in the family are ones which can be effectively addressed through family work.

Educational Prevention Programs

Jaffe et al. (1990) stated that "professionals in the field of family violence consistently stress the importance of primary prevention programs to change the underlying attitudes and behaviors that condone and promote violence between family members" (p. 90). In fact, some educational projects attempting to prevent wife assault by teaching school children about family violence have been piloted in some secondary schools and upper elementary grades across Canada (MacLeod, 1987). In one project in the United States, (Stavrou-Petersen & Gamache, 1988, cited in Jaffe et al., 1990) which was evaluated, the researchers reported that while the program did not appear to lead to any significant differences in attitudes about violence, the program did contribute towards signficant increases in knowledge about family violence issues (Stavrou-Petersen & Gamache, 1988, cited in Jaffe et al., 1990). It is noteworthy that the researchers discovered a high level of dating violence amongst the students at pretest-with 34% of girls having experienced dating violence. This suggests that intimate violence is an issue of concern for this population, not only with respect to their future adult relationships, but also their current peer relationships.

Summary

A variety of programs for child witnesses are offered in shelters and the community, including group counselling, individual therapy, family therapy, and educational prevention programs. However, little is presently known

about the effectiveness of these interventions, since few have been formally evaluated. The results of the research conducted with community-based groups are encouraging. The groups seem to be associated with some positive changes, including the development of more safety skill strategies, a more positive perception of the parents, healthier attitudes and responses to anger, increases in self-esteem,and the development of new, nonviolent ways of solving problems. Two of the researchers reported that children experienced a decreased responsibility for the violence, however, two others found no change on this variable. An evaluation conducted of an educational prevention program was also positive, in that the program was effective in helping children to increase their awareness of family violence.

Knowledge about the effectiveness of interventions for child witnesses of violence is sparse. Until more research projects are conducted, it is difficult to know to what extent programs such as short-term group counselling can help to ameliorate some of the effects upon children of witnessing parental violence. As Peled and Edleson (1992) state, "our collective knowledge of the change achieved through intervention with children of battered women and of the processes through which change occurs is in its incipient stages. There is a clear need for a better understanding of both the intended and unintended results of such programs, and of the ways in which these results occur" (p. 328).

A general consensus in the literature is that, in order to best help child witnesses, interventions should ideally take place at many different levels. Children's programming, "must occur in the context of comprehensive interventions for victims/survivors and perpetrators" (Peled & Edleson, 1992, p. 340). Hurley and Jaffe (1990) conclude that, "fundamentally, the clinical

intervention must be integrated into an overall community response by mental health, social service, and legal professionals that does not silently condone violence against women and children" (p. 475).

Rationale for the Present Study

The gap in knowledge in the efficacy of intervening with child witnesses of interparental violence has guided the development of the present study. As previously discussed, child witnesses are characterized by internalized and externalized adjustment problems (Hughes, 1988; Jaffe et al., 1986a; Alessi & Hearn, 1984). Several researchers have described and evaluated a group counselling program, intended to assist children with these adjustment difficulties (Jaffe et al, 1990; Wagar, 1991; Peled & Edleson, 1992) . Jaffe et al. (1990) stated that, "the group deals with the most important areas of emotional, behavioral, and cognitive problems associated with witnessing wife assault", and it tries, "to address children's adjustment difficulties as well as the more subtle symptoms related to attitudes about violence and responsibility for adult behavior" (p. 87).

The present study is concerned with the extent to which a ten week group counselling program, similar to those described in the literature, is associated with positive changes in the children's adjustment. The focus will be upon two particular areas of adjustment which have been noted by researchers as relevant to the experiences of child witnesses - anxiety and self-esteem (Hughes, 1988; Alessi & Hearn, 1984; Jaffe et al., 1990).

Most of the previous research exploring the association between the group interventions and children's adjustment has relied upon secondary reports of the child's behavior, such as asking the mother to complete the Child

Behavior Checklist (e.g. Jaffe et al., 1986a). However, there are disadvantages to relying upon such secondary sources, in that other factors such as a mother's stress, distortions in her own perceptions, and gender biases may negatively influence her rating of her children's behavior (Hughes, 1988; Jaffe et al., 1990). The intent of the present study was, therefore, to seek information about changes in children's anxiety and self-esteem from the children themselves, supplemented by the mothers' observations.

Implications for Social Work Practice

After many years of being overlooked, the children of battered women are now commanding more attention both in the literature and in program delivery. However, as has been discussed in this review, there is limited knowledge about the effectiveness of various interventions. It is essential from a practice point of view that social workers know what effect their services have upon child witnesses - both in terms of the intended and the unintended outcomes (Peled & Edleson, 1992). Research which explores the impact upon child witnesses of the various helping strategies, techniques, and therapies will enable workers to base their interventions upon a sound knowledge base.

An increased understanding of interventions with child witnesses has significance for the social work profession from two other standpoints. First, in providing support and therapeutic assistance to children of battered women, practitioners are not only addressing treatment issues but are also addressing prevention. Gondolf (1988) notes that child witnesses, "need assistance in recovering from the trauma of abuse and adjusting to a new life, in order to avoid reenacting the abuse in their adult life" (p. 102). Efforts to moderate the effects of family violence upon children can thus be viewed to be in the realm of

prevention - presumably the most favourable type of intervention from a social policy perspective.

Secondly, it is difficult to secure funding for programs and to promote progressive social policies without empirically-based knowledge about the effectiveness of social work interventions. To date, the few programs which have been evaluated appear to be beneficial in ameliorating some of the effects associated with exposure to family violence (Peled & Edleson, 1992; Wagar, 1991; Grusznski et al. 1988; Jaffe et al., 1988). If research continues to demonstrate the usefulness of programs for child witnesses, then perhaps governments and other funding bodies will be more likely to respond with increased support for children's programming both within shelters and in the community.

CHAPTER THREE

METHOD

General Description of the Program and the Evaluation Process

The ten week group counselling program for children at the Y.W.C.A. Support Centre is designed for children 5 - 13 years of age who have witnessed and/or experienced domestic abuse. The children are clustered into groups according to age and developmental stages, so there are separate groups for 5-7 years olds, 8-11 year olds, and 12-13 year olds. For the children aged eight and older, Wagar modified the program which she evaluated in 1991, which was originally very similar to the group intervention described by Jaffe et al. (1986c). The groups focus upon attitudes and responses to anger, knowledge of safety skills, and attempting to relieve the sense of responsibility for parents and for the violence. The program for the 5-7 children was further modified by Tutty and Wagar (1994), so that the groups are better suited to the particular developmental needs of this age group. In general, the programs address the following content:

1) Providing peer support for a shared problem;

2) Learning to identify and express feelings;

3) Conflict resolution;

4) Developing a sense of responsibility for behaviours;

5) Developing and enhancing support systems;

6) Building self confidence, self-esteem;

7) Understanding separation and loss;

8) Learning about self and relating self to the environment;

9) Providing an understanding of the dynamics of domestic abuse;

10) Problem solving;

11) Learning to deal with one's own anger and the anger of others.

The groups which were evaluated in the present study began in April and September of 1994, and were offered either on Saturday mornings or afternoons for a ten week period. The sessions were 1.5 hours in length, and a parenting group was offered concurrently for any interested parents. Each children's group was led by two facilitators - sometimes a male and female team, sometimes two females. The minimum qualifications for a group facilitator at the Y.W. Support Centre is a University degree, prior experience in leading a group, and a knowledge of family violence. Referral sources for the groups included the schools, women's shelters, and child welfare workers.

Definitions of Variables

The variables in the present study are defined as follows:

wife abuse - physical, sexual, psychological, and/or economic abuse of a woman by a common-law partner or spouse in an intimate relationship. This definition is utilized at the Y.W.C.A. Support Centre.

child witnesses of wife abuse - children who see their fathers, or other intimate partner of their mothers, abuse their mothers (as per the definition of wife abuse cited previously), overhear this behavior from another part of their home, or are exposed to the results of this abuse without hearing or seeing the commission of any aggressive act. (derived from Jaffe et al., 1990).

self-esteem - "a relatively stable set of self-attitudes reflecting both a description and an evaluation of one's own behavior and attributes" (Piers, 1984, p.1).

anxiety - incorporates both state and trait anxiety, where state anxiety is experienced by an individual as "unpleasant, consciously-perceived feelings of tension and apprehension, with associated activation or arousal of the autonomic nervous system" (defined by Spielberger, cited in Reynolds & Richmond, 1985, p. 3). These feelings arise when a person perceives a situation as threatening, regardless of whether a real threat exists (Reynolds & Richmond, 1985, p. 3). Trait anxiety "describes the personality of an individual who frequently experiences anxiety, often where the strength of the stimulus for evoking anxiety is relatively weak" (Reynolds & Richmond, 1985, p. 3). This latter form of anxiety, trait anxiety, is the type of anxiety measured in the present study, because the purpose of the study is to measure changes in the more stable personality patterns of an individual, rather than the transitory states.

Research Questions and Hypotheses

The main purpose of the research was to explore two questions:

1) Do child witnesses of wife abuse report positive changes in their self-esteem levels following their participation in the ten week group counselling program at the Y.W. Support Centre?

2) Do child witnesses of wife abuse report positive changes in their anxiety levels following their participation in the ten week group counselling program at the Y.W. Support Centre?

As a supplement to the study, a third, more general, question was posed:

3) What are the perceptions of mothers regarding the value and effectiveness of the ten week counselling program at the Y.W. Support Centre for their children?

Specific hypotheses regarding the self-esteem and anxiety variables were posed:

1) Child witnesses of wife abuse will report an increased level of self-esteem following their participation in a ten week group counselling program.

2) Child witnesses of wife abuse will report a decreased level of anxiety following their participation in a ten-week group counselling program.

Because the supplementary research question is exploratory, no hypothesis was developed for it.

Additional Research Questions

As has been previously discussed, research has demonstrated that the impact of witnessing wife assault may be influenced by a child's age, gender, and whether or not he or she was abused. Hughes (1988) states, for example, that, in regard to measuring the effects of witnessing violence, her findings, "lend strong support to the contention that children need to be divided into age groups" (p. 85). She further asserts that, "accurately classifying children into abused and nonabused categories is crucial for understanding the psychological functioning of the children and their responses to different external factors" (p.

86). In comparing the adjustment of girls and boys from violent homes, Jaffe et al. (1986a) and Davis and Carlson (1987) found that there were significant differences between the two groups. Given the importance of these mediating variables, it was decided to also investigate whether younger children reported more or less changes in self-esteem and anxiety than older children, whether abused witnesses reported more or less changes on these variables than non-abused witnesses, and finally, whether the girls reported more or less changes than the boys. Since these were also exploratory questions, no hypotheses were developed.

Research Design

The main component of the present study utilizes a pretest-posttest one-group design. The design can be conceptualized as follows:

$$O_1 \; X \; O_2$$

Where:

O_1 = the first observation of the dependent variable: the scores on the self-esteem scales and the scores on the anxiety scales.

X = the independent variable: the group counselling program

O_2= the second observation of the dependent variable: the scores on the self-esteem scales and the scores on the anxiety scales.

The above research design is considered to be exploratory, where the intent of the study is simply to investigate further the area of interventions with child witnesses, and to contribute ideas and tentative hypotheses to the field. Since there has been so little research in this area to date, the use of an

exploratory design is an acceptable choice - thus contributing knowledge which might "pave the way" for more rigorous, experimental research designs in the future (Grinnell & Stothers, 1988).

With this design, it is possible to discover whether minimum standards of outcome are being achieved, how well the children are functioning at the end of the program, and to find out how much the participants changed over the course of the ten week group. However, it is not possible to attribute any changes in the participants to the group program itself, because threats to internal validity such as history, maturation, and testing are not controlled in the pretest-posttest one-group design (Grinnell & Stothers, 1988). Thus, any significant changes could also have occurred because of another event that had an impact on the children, or because they matured. Finally, taking the pretest may have influenced how the children responded to the measure at posttest.

Measures

Two instruments were utilized to measure the self-esteem of the study participants. For the older children (8-13 year olds), the Piers-Harris Children's Self-Concept Scale was used, while the younger children, (5-7 years olds) responded to the McDaniel-Piers Young Children's Self-Concept Scale. Anxiety was measured by the Revised Children's Manifest Anxiety Scale for the entire sample of children.

The Piers-Harris Children's Self-Concept Scale

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

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

The Piers-Harris Children's Self-Concept Scale was standardized on 1183 children in grades 4 through 12 in a small American town (Jeske, 1985). The scale appears to be a highly reliable instrument for measuring the self-concept of children 8-18 years of age. Studies of the test-retest reliability of the instrument have resulted in coefficients ranging from .42 to .96, with a median correlation figure of .73, suggesting that the test demonstrates a reasonable degree of stability (Cronbach, 1970). These fairly solid correlations also suggest that childrens' self-attitudes are fairly stable by the age of eight (Piers, 1984). The alpha coefficients on a number of normative samples ranges from .88-.93, indicating that the instrument has a high degree of internal consistency.

Studies exploring the concurrent validity of the Piers-Harris scale have reported a range of results. Piers (1984) states that this range may be due, in

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

Finally, the factorial validity of the Piers-Harris scale has been investigated in a number of studies, the results of which are somewhat mixed. While several studies replicated many of the factors identified in the original factor analysis carried out by Piers in 1963 (Piers, 1984), others, "have identified additional factors or failed to replicate all six original factors" (p. 66). This has led Piers to conclude that "caution should be taken when interpreting specific cluster scales, especially for individual children" (p. 66). In general, however, this scale is considered to be "psychometrically sound" (Jeske, 1985). According to this reviewer, "the Piers-Harris appears to be the best children's self-concept measure currently available. It is highly recommended for use as a classroom screening device, as an aid to clinical assessment, and as a research tool" (Jeske, 1985, p. 961).

The McDaniel-Piers Young Children's Self-Concept Scale

This scale is a downward extension of the Piers-Harris Children's Self-Concept Scale (Johnson, 1976). In developing the scale, items from the original scale which were of relevance to 5-7 year olds were selected, and the

wording simplified. The test administrator reads the items aloud, and the children respond on answer sheets which have been modified so that reading skills are not required. The scale consists of 40 items, and provides a total score and three subscale scores: Feeling Self, School Self, and Behaving Self.

Normative data on the instrument is based on over two thousand children from eight metropolitan school systems in the United States. The coefficient alpha (KR-20), computed for 20 elementary school classes (McDaniel, personal communication, Feb. 20, 1991), was .83 for grades 1 and 2, and .87 for grades 3 and 4. This suggests that the instrument is internally consistent (Corcoran & Fischer, 1987), meaning that there is a fairly high correlation among the items in the test. Hughes (1983, cited in Hughes, 1984), reported that she obtained a test-retest reliability coefficient of .65 when measured on 59 participants over an eight week period. She pointed out, however, that additional information about the psychometric properties of this scale is needed. In particular, further information about the test-retest reliability of this instrument would be very helpful, especially since some researchers have suggested that self-concept may be less stable in younger children who are only just forming images of themselves (Harter, cited in Piers, 1984). Correlations between teachers' rankings of students and self-concept scores ranged from .-01 to .58, with a median correlation of .32.

While this instrument, "shows promise of being developed into a sound measure" (Hughes, 1984, p. 668), the general lack of information on the scale's reliability and validity means that the results of the sections of the present research which focus on younger children's self-esteem, must be interpreted cautiously. The McDaniel-Piers Young Children's Self-Concept Scale was

selected for use in the present study because of its similarity to the parent-version, the Piers-Harris Children's Self-concept scale. The Piers-Harris scale is, as previously mentioned, a generally reliable and valid instrument, but it was not designed for children younger than 8 years old. Thus, the close resemblance of the McDaniel-Piers to the Piers-Harris made it a logical choice in the present study. Furthermore, there are virtually no other standardized measures available for use with the youngest elementary school children (Hughes, 1984).

The Revised Children's Manifest Anxiety Scale (RCMAS)

This scale is a 37-item, self-report instrument designed to measure the level and nature of trait anxiety in children and adolescents from 6 to 19 years old. The scale provides four subscales scores: physiological anxiety, worry/oversensitivity, social concerns/concentration, and lie. Respondents simply reply "yes" or "no" to whether the statements on the instruments reflect their own experiences of themselves. High scores on the total scores or on the subscales reflect a high level of overall anxiety, or a high level of anxiety on the dimension measured in the particular subscale.

The originators of the scale reported on its content validity, stating that the items were developed by researching aspects of anxiety, and by consulting with teachers, child clinical psychologists, and school psychologists (Reynolds & Richmond, 1985). A distinction is drawn between state and trait anxiety, where "trait anxiety is a more lasting predisposition to experience anxiety in a variety of settings" (Reynolds & Richmond, 1985, p. 29). The authors explain

that because they are measuring trait anxiety, "scores should be relatively stable across time" (p. 29).

The RCMAS was normed by race and sex on a large sample of 4,972 school-aged children ages 6-19 (Reynolds & Richmond, 1985). This scale has a high degree of internal consistency, with an alpha coefficient of .83 for the Total Anxiety Score on the test development sample of 329 children (Reynolds & Richmond, 1985). Another sample of children from grades 2 - 11 yielded similarly high results - a KR-20 of .85. For the subscales, the reliability estimates are as follows: physiological anxiety - generally in the 60;'s and 70's, except for above the age 15 where the estimates are in the .50's; worry/oversensitivity - reliability estimates are in the .70's and .80's; social concerns/concentration - reliability estimates are mostly in the .60's; the lie subscales - reliability estimates are in the .70's and .80's. Reynolds and Richmond (1985) state that, "for most research purposes, the subscales are reliable enough to be used, provided sample sizes are reasonable" (p. 27).

Reynolds has reported (cited in Reynolds & Richmond, 1985) a test-retest reliability coefficient of .68 for the Total Anxiety score for 534 elementary school children tested nine months apart. Given the lengthy period of time, these results "give reasonable evidence of stability of general trait anxiety" (Reynolds & Richmond, 1985, p. 28). With a three week interval between testing, other research has demonstrated a very high test-retest reliability coefficient of .98 for this scale.

The RCMAS has been shown to have a high degree of convergent validity. A correlation between the State-Trait Anxiety Inventory for Children (Trait Scale) and the RCMAS was found to be highly significant at .85 ($p <$

.001). The authors conclude that the results of this study, "provide considerable support for the construct validity of the RCMAS as a measure of chronic manifest anxiety, independent of state or situational anxiety" (Reynolds & Richmond, 1985, p. 36). The RCMAS also correlated positively with teacher observations of classroom behavioral problems (Reynolds, cited in Harrington, 1984). Finally, a factor analysis in which three factors were identified (Physiological Anxiety, Worry and Oversensitivity, and Concentration Anxiety) showed that the factors held across sex and race, with reliability coefficients for each factor generally in the .60 -.80 range (Reynolds & Paget, cited in Harrington, 1984). It would, thus, appear that there is considerable support for the reliability and the validity of the RCMAS.

Research Procedures

The research instruments were administered to children during the intake process, one to two weeks prior to the commencement of their group, and again at the conclusion of their program. The timing of the administration of the post-tests varied somewhat because of some logistical constraints, however, they were administered to the children no sooner than the second to last group meeting, and no later than one month following the termination of the group.

Children completed the instruments with the help of, or in the presence of, the Administrative Supervisor at the Y.W.S.C., the group facilitators, and/or the researcher. The research sample consisted of all 5-13 year old children who completed the pre-tests, who attended the ten week group counselling program, and who completed the instruments at the time of the administration of the

post-tests. Pre-test data was also collected from the remaining 5-13 year old children who were not present for the post-tests.

Demographic information, as well as information about the familial histories of violence, was collected from the files of those children who completed the post-tests. At the time of intake, the mothers of the children attending the groups are asked by Y.W.S.C. staff to complete a "Pre-group Assessment" form. This form provides demographic information for the group facilitators, as well as details of the nature and the severity of the violence occurring in the families. A decision was made to collect information in this secondary manner because the specific information required for the present study had already been collected by the Y.W.S.C. staff, and it would have been not only redundant but burdensome for the mothers to have to repeat the same information again to the researcher.

Telephone Survey

The supplementary research question,"What are the perceptions of mothers regarding the value and effectiveness of the ten week counselling program at the Y.W.Support Centre for their children?" was investigated using a telephone survey. A set of structured questions was developed with the assistance of experts in the field, and by a review of the literature. Respondents were selected using convenience sampling - relying upon the "closest and most available subjects to constitute the sample" (Gabor, 1993). All mothers of children attending counselling groups were given information about the telephone survey during the intake process, along with a consent form (See Appendix 1). The researcher then contacted the mothers who had

signed the consent form within one month following the groups' termination, until reaching an adequate sample size of nineteen. As is typical with any telephone survey research (McMurtry, 1993), the researcher was not able to contact many of the respondents who had originally consented to the research. Because convenience sampling is a nonprobability sampling method, the generalizability of the results to the total sample is limited. It may be, for example, that the mothers who consented to the research and who were available by phone were not representative of the total sample. However, given that the survey was intended merely as a supplement to the main part of the study, the convenience method of sampling was considered to be most practical way to collect information on the mothers' views of the group.

The telephone survey was selected as a research method because it allows for longer, more detailed responses than a written survey. Participants are more able to respond spontaneously without self-censorship in a conversation with a researcher. The telephone survey can also be responded to more easily by participants who may have difficulty with reading and writing skills. Furthermore, it allows the researcher an opportunity to clarify questions for the respondent (McMurtry, 1993).

Some of the disadvantages of the telephone survey include the inability of the researcher to perceive nonverbal responses, and a general unwillingness of respondents to answer sensitive questions over the telephone (McMurtry, 1993). Some other disadvantages of the telephone survey include those that are inherent in any type of research method relying upon self-report data. Bailey (cited in Gochros, 1988) states that error and biases may occur in self-reported data due to the respondents deliberately lying, accidentally making

mistakes in their responses, or not being able to remember. Another disadvantage of a personal interview is the loss of anonymity. Despite reassurances to the contrary, respondents might be reluctant to make "negative" comments, for fear of retribution (i.e. mothers of children attending the Support Centre may be planning to attend future groups, and be worried about negative repercussions to themselves or their children). Although the interviewees' responses may be adversely affected by other extraneous factors, such as demands of children or an emotional state not conducive to being interviewed, the researcher attempted to ensure that the telephone interview took place at a time which was convenient to the participant.

The survey instrument consisted of a set of structured questions (see Appendix 2), which were asked of each participant in the same order. Most of the questions were open-ended. Such questions are useful in cases, like the present study, where, "all of the possible issues (and responses) involved in a question are not known or when the researcher is interested in exploring basic issues and processes in a situation" (Mindel, 1993, p. 228). Open-ended questions generate more data and allow the respondent a greater range of expression than closed-ended questions. However, its disadvantages may include decreased external and internal validity because some respondents who are not very articulate may have difficulty with open-ended questions. Also, the researcher codes and categorizes responses, introducing an element of subjectivity to the study. The interviewer may unintentionally influence the response of the research participants by her tone of voice, emphasis upon certain words, or the phrasing of questions (Gochros, 1988). All of these

factors may adversely affect the reliability and validity of the information gathered in the telephone survey.

Ethical Considerations

The present study was, with the exception of the telephone survey, incorporated as part of the Y.W. Support Centre's normal evaluation process. The Y.W.S.C. regularly administers pre-tests and post-tests to the participants in their programs, in order to consistently evaluate the effectiveness of their groups. Several steps were taken by both the researcher and the Y.W.S.C. staff to ensure adherence to ethical standards. When the parents initially registered their children in the counselling groups at the Y.W. Support Centre, they were given a consent form (see Appendix 3), which explains the purpose and the content of the group. The parents were informed that pre and post test data was collected from all children and themselves on an ongoing basis in order to evaluate the effectiveness of the program. Reference was made to the variables of concern in the present study, self-esteem and anxiety, so that parents were aware that their children would be completing standardized forms which measure these traits. The consent form stressed that participation in the program is completely voluntary, and that they are free to withdraw at any time. The form also specifies a commitment on the part of the staff to provide feedback to the parents with respect to their children after the termination of the group. The consent form assured participants that all information received from parents and children would be treated confidentially, except in cases where the staff are obligated by law to report to Child Welfare any child who is in need of protection.

Mothers of children in the counselling groups were also given a consent form referring specifically to the present study, and requesting the mother's participation in the telephone survey (see Appendix 1). Mothers were assured of the confidentiality of their responses, again subject to the provisions of the Child Welfare Act. It was stated in the form that the mothers were free to withdraw from the research at any time, that they could refuse to answer any questions, and that this would in no way affect their participation in the Y.W. Support Centre's programs. All identifying information was removed during the analysis of the data, and the notes are stored in a locked office at the University of Calgary. This information will be destroyed within one year, upon completion of the study. Other data, collected from the standardized instruments, was returned to the Y.W.S.C. files following data analysis.

Summary of Limitations and Strengths of the Research

The results of the study must be interpreted with caution because of limitations inherent in the research design. In testing the two hypotheses, control groups were not used, so that one cannot determine whether changes in the children's self-esteem levels and/or anxiety levels were attributable to the group. Furthermore, while, in general, the instruments used are sound, there are several limitations which must be taken into account. While there is considerable support for the use of the Piers-Harris total scores, the Piers-Harris subscale scores need to be interpreted with caution (Hughes, 1984). Also, while the Piers-Harris has been assessed by Hughes (1984) as the best scale for clinical use with older children, she states that, "a cautionary note must be sounded with regard to the influence of a social desirability response

set" (p. 668). She explains that because of the dichotomous format of the instrument, children who feel neutral may respond in a positive direction. Finally, as has been previously mentioned, the results of the McDaniel-Piers scores will certainly need to be treated carefully.

The conclusions drawn from the telephone survey research can only be considered valid with respect to the mothers who participated. Nonprobability sampling was used, thus, the results are not generalizable. Since people are generally hesitant to discuss highly sensitive material over the phone, the mothers may have left out some important information in the interview. The open-ended questions allowed for the generation of data, but may have detracted from the validity and reliability of the information gathered.

Despite the limitations of the research, the results of the present study should nevertheless be useful and of interest. In the preceding chapter, it was noted that there is a paucity of research evaluating intervention programs with child witnesses of parental violence. A strength of the present study is, therefore, the contribution it makes to this gap in the literature. Furthermore, a unique aspect of the present study is the utilization of self-report measures in examining changes in self-esteem and anxiety amongst child witnesses in counselling groups. To the writer's knowledge, no previous studies have used such self-report measures in this type of evaluation. Two of the three scales used in the research, the Piers-Harris Children's Self-Concept Scale, and the Revised Children's Manifest Anxiety Scale, have been well-tested and have been assessed as psychometrically sound. The third, the McDaniel-Piers Young Children's Self-Concept Scale, has not yet been subjected to rigorous psychometric testing, but it shows promise and may also prove to be a reliable

and valid instrument with further research. A further strength of the present study is that it investigates the impact of the group counselling program on a wide age range of children. Measures were administered to children 5-13 years of age.

The supplementary telephone survey enhances the research in that it adds valuable anecdotal information about the children's feelings, attitudes, and behavior from the mothers' point of view. It has been suggested that parents and children "differ in the type of information they can immediately assess" (Beitchman & Corradini, 1988, p.486), and, therefore, information from both sources increases the accuracy of conclusions drawn about changes in the children's level of functioning (Beitchman & Corradini, 1988).

CHAPTER FOUR
RESULTS

The purpose of this chapter is to present the research findings from the current study, including the demographic information from the children in the sample, data on the extent of the violence they had witnessed or experienced in their families, and the results of the standardized self-esteem and anxiety measures. Finally, the outcome of the supplemental telephone survey research will be presented.

Demographic Information

The mean age of the 49 children in the pre-test/post-test sample was 7.7 years. Most of the children were between 5 and 13 years of age, however, one 4 year old was included in the 5-7 year old group, and one 14 year old in the 12-13 year old group. There were considerably more boys (64%) than girls (36%). The majority of the mothers of the children were divorced or separated (74%). A further 12.9% of the mothers were still married, and 9.7% were living common-law. The average monthly income of the mothers was $1588. Calculated on a yearly basis, this would be the equivalent of $19,056 - indicating that the families in the sample generally had a low level of income . Most of the mothers were working (44%), 28% were on social assistance, 12% were receiving student loans, 8% were receiving income from their husbands, and another 8% were receiving unemployment insurance. Finally, the mothers in the sample were fairly well educated, with almost 50% having received some form of post-secondary education. Another 32% had completed high school.

Ninety three percent of the mothers had custody of the children, as compared to only 3.4% of the fathers. Someone other than the parents had custody in another 3.4 % of the cases. Most of the fathers (81.5%) had visitation rights.

The Extent of Violence in the Families

The mean number of years that the women were in a relationship with their abusive partners was 8.5 years (s.d.= 6.13). Reporting on the nature of the violence, 97% of the mothers stated that they had been emotionally abused by their partners, 78% had been physically abused, and 31% had been sexually abused. About one third (37%) stated that they had a restraining order in place to protect them from their partners. Almost half (48%) had been involved with only one abusive partner, 19.4 % had been involved with two abusive partners, 9.7 % with three, and 6.5% with four. Twelve percent of the women denied having been involved with an abusive partner, suggesting that women may have interpreted the question to refer only to physical abuse, since most of the women reported histories of emotional abuse in another question. One woman (3.2%) reported that she had been involved with nine abusive men.

In terms of the children's experience of violence, the mothers reported that a high percentage had been abused, themselves, with 80% of the children having been emotionally abused, 61% physically abused, and 15.6% sexually abused. Thirty eight percent of the women reported that child welfare authorities were currently involved with their family.

A large number of the children had witnessed parental violence in the past. Mothers reported that 56% of their children had witnessed the physical abuse by their partner in the past, 54% of the children had witnessed emotional abuse, and 2% had been present during their sexual abuse. In terms of the frequency of witnessing the violence, mothers reported that it occurred constantly for 29.4% of the children, frequently/often in 38.2% of the cases, occasionally/sometimes for 23.5% of the children, and finally, rarely for 8.8% of the children. The numbers of children currently witnessing violence were fewer. Twenty-two percent of the children were currently witnessing the physical abuse of their mothers, 44% the emotional abuse, and 2% were witnessing sexual abuse.

In sum, all of the mothers experienced some form of abuse at the hands of their partners. Their children frequently witnessed this abuse, and a large number were victims of abuse themselves.

Self-Esteem

The self-esteem of the 8-14 year old children was measured by the Piers-Harris Children's Self-Concept Scale, while the self-esteem of the 5-7 year old children was measured by the McDaniel-Piers Children's Self-Concept Scale. In the following section, the analysis of the older children's scores on the Piers-Harris scale will be discussed prior to the analysis of the younger children's scores on the McDaniel-Piers scale.

The primary investigation in the current study focused upon a comparison between the children's pre and post-test self-esteem scores. However, since there has been so little research investigating the self-esteem

and anxiety levels of child witnesses with the use of self-report measures, and since it is of interest to know how the scores of the children in the sample compared with the scores of children from non-violent homes, the pre-test scores of the children were first analyzed and compared with normative data. Because some children dropped out of the program following the pre-test, and because others were not available for the post-tests, there was a much larger sample of pre-test scores than pre-test/post-test scores. Obviously for the purposes of comparing the pre-test data to normative populations, a large sample size is desirable. Therefore, for the Piers-Harris scale, data from the total sample of children will be presented.

Interestingly, as can be seen in Table 1, the average Piers-Harris self-esteem scores of the older children (8-14 year olds) were within the normal range at pre-test. Keeping in mind that higher scores correspond with higher levels of self-esteem, and vice versa, the mean of the pre-test standardized scores of the 49 children in the total sample was 54.28, with a standard deviation of 10.73. As per convention, the mean of standard scores is 50, with a standard deviation of 10, so it is clear that the scores of the study sample fall within the normal range. Similarly, the average of the standardized subscale scores of the total sample of older children were also within the normal range at pre-test.

The dependent t-test statistical procedure was used to analyze any changes from pre-test to post-test from the research sample of 18 children. As can be seen in Table 2, no statistically significant changes were found in either the total self-esteem scores or any of the self-esteem subscale scores following the children's participation in the group counselling program.

Table 1: Piers-Harris Children's Self-Concept Scale -Mean T-scores of the Total Sample of Older Children at Pre-test (N=49)

Variable	Mean T-score**
Total Self-Esteem Score	54.28 (s.d. 10.73)
Behavior	48.71 (s.d. 10.67)
Intellectual/School Status	54.61 (s.d. 11.06)
Physical Appearance	56.08 (s.d. 9.7)
Anxiety	51.73 (s.d. 11.22)
Popularity	46.31 (s.d. 9.7)
Happiness	51.75 (s.d. 10.94)

**for comparison, mean of standard scores = 50, s.d. = 10

Table 2: t-tests of Pre and Post Piers-Harris Children's Self-Concept Scale Scores -Total and Subscale T-scores (N=18)

Variable	Mean pre-test score	Mean post-test score	df	t-value	1-tailed probability level
Total Self-Esteem	49.39 (s.d.=11.51)	50.01 (s.d.=14.02)	17	.41	.34
Behavior	43.33 (s.d.=9.55)	43.11 (s.d.=10.96)	17	-.13	.45
Intellectual/ School Status	51.33 (s.d.=12.42)	48.56 (s.d.= 12.50)	17	-1.4	.09
Physical Appearance	51.28 (s.d.=10.60)	49.67 (s.d.=13.06)	17	-.90	.19
Anxiety	48.22 (s.d.=12.47)	48.44 (s.d.=12.76)	17	-.12	.45
Popularity	44.06 (s.d.=12.30)	42.78 (s.d.=11.04)	17	-.82	.21
Happiness	46.22 (s.d.=12.88)	45.39 (s.d.=15.95)	17	-.36	.36

The younger children, aged 5-7, completed the McDaniel-Piers Young Children's Self-Concept Scale. The pre-test/post-test sample of younger children was larger than the sample of older children; 31 young children completed this scale before and after their participation in the group counselling program. No additional data was analyzed from those young children who did not complete the post-tests, therefore, the pre-test scores of the 31 children in the pre-test/post-test sample were compared with normative data. Standard score conversions are not utilized for this scale. In the normative sample (Johnson, 1976), which consisted of 20 elementary school classes in the United States, the grade one children had mean scores of 22.85 and 25.87, respectively. Unfortunately, no information about the standard deviations of these scores is available. As can be seen in Table 3, the mean pre-test scores of the child witness group in the study was 27.12, with a standard deviation of 7.87. The self-esteem subscale scores of the child witness group were also comparable to the scores of the normative sample. Thus, when comparing the mean of the child witness' raw scores with that of the normative sample, it appears that, on average, the child witness' scores on the McDaniel Piers Young Children's Self-Concept Scale are at least within the normal range, if not a little higher than the scores of the norm group.

Referring again to Table 3, using the dependent t-test analysis, no statistically significant changes were found between the pre and post-test total scores for the sample, nor for the behavior, feeling, and school subscales, although changes on the behavior subscale approached significance.

Table 3: t-tests of Pre and Post McDaniel-Piers Young Children's Self-Concept Scale - Total and Subscale Raw Scores (N=31)

Variable	Mean pre-test score	Mean post-test score	df	t-value	1-tailed probability level
Total score	27.13 (s.d.=7.87)	28.55 (s.d.=6.51)	30	1.25	.11
Behaving Self	6.52 (s.d.=2.99)	7.19 (s.d.=2.61)	30	1.51	.07
Feeling Self	10.26 (s.d.=4.01)	10.52 (s.d.=3.64)	30	.80	.21
School Self	10.03 (2.27)	10.52 (s.d.=2.54)	30	1.09	.14

Previous research has highlighted the differences in adjustment between non-abused and abused child witnesses, and it is frequently recommended that researchers distinguish between these two groups of children (Davis & Carlson, 1987; Hughes, 1988). In the present study, a child's abuse status was determined by their mother's response on the intake form - they replied "yes" or "no" to questions about whether or not their child was abused. As can be seen in Table 4, when the scores of the physically abused witnesses were analyzed separately from the non-abused witnesses in the present study, the 5-7 year old children who were physically abused did report statistically significant improvements in self-esteem following their participation in the group counselling program. The mean of their pre-test scores were also slightly lower than the mean scores of the total sample (27.13). The same statistical procedure was used to determine whether abuse status was a possible mediating variable with the older children, however, no significant results were found.

Anxiety

The Revised Children's Manifest Anxiety Scale was administered to all of the children in the sample, since it was designed for use with children 6-18 years of age, and there is empirical support for its use with five year old children (Reynolds & Richmond, 1985). As was the case with the Piers-Harris scale, the number of children completing this instrument at pre-test were considerably greater than the number of children completing the anxiety scale at both pre-test and post-test. Again, for the purposes of comparing the anxiety levels of child witnesses at pre-test with those of the normative

Table 4 : t-tests of McDaniel-Piers Young Children's Self-Concept Scale - Physically and Non-Physically Abused Children

Variable	Mean of pre-test scores	Mean of post-test scores	df	t-value	1-tailed probability level
Total score of Physically Abused Children (N=17)	26.24 (s.d.=6.51)	29.35 (s.d.=6.45)	16	-2.25	.019**
Total Score of Non-Physically Abused Children (N=9)	29.22 (s.d.=7.78)	28.11 (s.d.=7.36)	8	.41	.35

population, the pre-test data collected from the total sample (N=81) will be presented in addition to the data collected from children who completed the post-tests.

A lie scale has been incorporated into the Revised Children's Manifest Anxiety Scale, which can be used to gauge the accuracy of the children's self-reports. Items on this scale refer to unrealistic, ideal kind of behaviors. For instance, items are included such as "I am always kind", "I like everyone I know". Reynolds and Richmond (1985) point out that a high score on the Lie subscale "may be quite indicative of an inaccurate self-report"(p. 10). With both the total sample and the sample of children who completed the post-tests, the means on this subscale were within normal ranges (see Tables 5 and 6). This suggests that, in general, it can be assumed that children in the research sample responded as accurately as the children in the normative sample.

As can be seen in Table 5, the average of the standardized anxiety scores of the total sample of 81 child witnesses at pre-test were within the normal range, with an average score of 51.80 (s.d.=12.50) , closely approximating the standard mean score of 50. The standardized subscale pre-test scores were also within the normal range.

As can be seen in Table 6, the 31 children who completed the RCMAS at both pre and post-test reported significantly less anxiety at post-test than before they began the group. The particular areas of anxiety in which participants reported statistically significant improvements were the total anxiety score, and the subscales of worry/oversensitivity and social concerns/concentration. There was no statistically significant change on the

Table 5 : The Revised Children's Manifest Anxiety Scale -Mean T-Scores of the Total Sample at Pre-test (N=81)

Variable	Mean of T-scores **
Total anxiety score	51.80 (s.d.= 12.50)
Worry/oversensitivity subscale	9.75 (s.d.= 3.15)
Physiological anxiety subscale	10.32 9 (s.d.=3.6)
Social concerns/concentration subscale	10.03 (s.d.=3.19)
Lie subscale	9.23 (s.d.=3.23)

** For comparison, standard total scores have a mean of 50 (s.d.=10), and standard subscale scores have a mean of 10 (s.d.=3).

Table 6: t-tests of Pre and Post Revised Children's Manifest Anxiety Scale Scores - Total and Subscale T-Scores (N=31)

Variable	Mean of pre-test scores	Mean of post-test scores	df	t-value	1-tailed probability level
Total Anxiety Score	56.74 (s.d.=12.76)	51.81 (s.d.=12.86)	30	1.76	.04**
Physiological anxiety	11.52 (s.d.=3.23)	10.45 (s.d.=3.71)	30	1.54	.07
Worry/over-sensitivity	10.87 (s.d.=3.15)	9.52 (s.d.=3.37)	30	1.98	.03**
Social concerns/ concentration	11.58 (s.d.=3.14)	10.32 (s.d.=3.5)	30	2.05	.03**
Lie Subscale	9.32 (s.d.=3.18)	8.90 (s.d.=3.20)	30	.70	.24

physiological anxiety subscale. The fact that scores on the lie subscale did not significantly change indicates that the children's self-reports were relatively stable and remained within the accurate range.

As has been previously discussed, the research of several authors has suggested that a child's age may be an important variable to consider when assessing the impact of interparental violence (Jaffe et al., 1990; Ragg, 1991; Hughes, 1988), and presumably, when evaluating intervention strategies. Because the RCMAS was administered to such a wide age range of children (4-14 years), dependent t-tests were conducted to explore whether younger children reported more changes in their anxiety levels than older children, or vice versa. Since the 4-7 year old children were given a different self-esteem instrument than the older children, and since they were also in a separate counselling group from the 8-11 and 12-13 year olds, it was decided to compare the 4-7 year olds with the other children in the sample. In fact, this analysis resulted in some striking differences, where the 13 younger children reported significant, positive changes in their anxiety levels at post-test, but the changes in the 18 older children were not significant (see Table 7).

Finally, while the literature suggests that gender may be an important mediating variable in terms of the impact of violence upon children (Davis & Carlson, 1987; Jaffe et al., 1986a), this was not the case in the present study. The changes in both the anxiety and self-esteem scores of the boys were analyzed separately from the girls, with the use of dependent t-tests, but no significant differences between the two groups emerged.

Table 7: Comparison of t-tests of Anxiety Total and Subscale T-Scores, Younger vs. Older Children

Variable	#of pairs	Mean of pre-test T-scores	Mean of post-test T-scores	df	t-value	1-tailed prob. level
4-7 yrs Total Score	13	59.00 (s.d.=14.1)	47.61 (s.d.=13.4)	12	1.95	.04**
Phys. Anx.	13	11.46 (s.d.= 2.9)	9.08 (s.d.=3.8)	12	1.96	.04**
Worry	13	11.38 (s.d.=3.4)	8.77 (s.d.=3.17)	12	1.98	.04**
Social Concerns	13	11.92 (s.d.=3.6)	9.46 (s.d.=3.5)	12	1.96	.04**
8-14 yrs Total Score	18	55.11 (s.d.=11.8)	54.83 (s.d.=11.9)	17	.15	.44
Phys.Anx.	18	11.56 (s.d.=3.6)	11.44 (s.d.=3.4)	17	.15	.44
Worry	18	10.50 (s.d.=2.9)	10.05 (s.d.=3.5)	17	.69	.25
Social Concerns	18	11.33 (s.d.=2.9)	10.94 (s.d. 3.5)	17	.66	.26

Results of the Supplemental Survey Research

The researcher conducted telephone interviews with 19 mothers, asking a series of structured survey questions to discover their impressions of the group counselling program and its impact upon their children. Detailed notes were taken from the telephone survey, which were then compiled, quantified, and summarized as follows.

Reasons For Deciding to Enroll the Children in the Group

The women were asked about their reasons for deciding to enroll their children in the group program. The majority (14) expressed being primarily concerned about their child's high level of anger, as well as inappropriate ways of expressing this anger.

A common problem related to anger was that family problems were "spilling over" to school, where children were releasing their feelings of anger inappropriately. In fact, three referrals to the Support Centre in this sample of 19 were from the child's school. One woman stated that her son was having violent rages in the classroom, and, at home, was physically assaulting his brothers, and throwing things around the house. In another case, the son was physically hurting other children at school on a daily basis. One of the interviewees reported that her six year old son had already been suspended twice from school because of his temper tantrums.

One mother had actually been physically assaulted by her son - he had broken her finger and was also verbally abusive towards her. Another expressed concern about her son taking his anger out on himself - he would

constantly put himself down and would frequently make statements like "nobody loves me". Finally, another mother noted that she had contacted the Support Centre out of desperation, feeling that she was at her "wits end", and that she could no longer cope with her child's anger and behavior problems on her own.

Five women expressed general concerns about the effects upon their children of having witnessed abuse. These women were approaching the problem proactively - wanting to discover if their children had any unresolved issues as a result of the violence in their homes, and if so, hoping to intervene before the problems worsened. One woman said, for example, that if her children had been emotionally disturbed by the witnessing of violence, she wanted to "nip it in the bud".

Another common motivation for enrolling children in the groups was a desire on the mother's part to end the cycle of violence. Five women talked about their worries that their sons would grow up to become abusers, and that their daughters would become victims. In the same vein, women mentioned that they wanted to increase their children's awareness and understanding of abuse. Others voiced concerns that their children did not express their feelings, that their children acted insecurely (i.e. bursting into tears over any small thing), and that they did not feel good about themselves.

Mother's Expectations of the Group

Many of the responses to the question of the mother's expectations of the group followed logically from the previous question regarding their motivation for enrolling their children in the group. Ten women hoped that

their children would learn to control their anger, and would also learn healthier ways of expressing this emotion. Nine expressed wanting their children to gain a better understanding of their feelings, and to learn to express and talk about feelings. Other mothers hoped that their children would learn more about abuse, and that it is wrong. One woman, speaking of her daughter, said poignantly, "I wanted her to come to the point where violence didn't feel right for her". Other expectations included: that children would feel empowered; that they would gain skills in assertiveness; that they would gain control over the aspects of their lives that they could control; that they would experience increased self-esteem and self-awareness; that they would learn that the problems the adults were having were not their fault; that children would learn that others have gone through the same thing, so they're not alone; that they would learn new communication skills, and finally, that they would simply have a fun and enjoyable experience.

Clarity of the Program's Purpose

The mothers were asked whether or not the purpose of the group had been explained clearly to them at the outset of the program. Eleven replied in the affirmative, five in the negative, and two were not sure. Of those who had not been clear about the purpose, one stated that she had lots of unanswered questions, especially when her son was "acting weird from the group". This mother said that she would have liked to have known more about the topics covered in the kids' groups, such as behaviors to watch for, and what to expect from the kids, so that she could have been better prepared for different behaviors. Three others stated that more information about the groups would

have been helpful at the outset. One other expressed that both she and her children had been taken aback when they found themselves with other families where serious forms of abuse had occurred.

Children's Reactions to the Group

The researcher asked women to comment on their children's reaction to the group. The majority of the interviewees (14) reported that their children looked forward to attending the groups, and they experienced the program as an enjoyable, fun activity. For instance, one woman said that her daughter liked going to the group so much that she cried on the three occasions that she was not able to attend. Another said that her daughter felt it was a safe place where, "she could feel whatever she wanted to feel". This woman mentioned that her son also really liked going to the group.

A common response regarding children's reactions was that they were initially reluctant to go, but then ended up liking the group. One woman commented that each Saturday her children did not want to go to the group, but afterwards they were always happy that they had gone. Another said that for the first session, her son was scared and didn't know anyone. Although he was still nervous for the second meeting, by the third session he was looking forward to the group.

Two women replied that their children seemed "neutral" about the group. For instance, one noted that her child did not hate to go, but he also did not really love it. She said that the group took him away from his Saturday morning cartoons, and that, "his heart was not really in it".

One woman noted her son did not like the group, and that it was difficult to get him to go each week. Another said that at times, her son was uncomfortable about the work that they did. One interviewee noted that her two children both expressed strong negative feelings about the building in which the groups were held. This woman said that the children enjoyed the group, but they found the physical facilities to be "so awful that it turned the children off the group".

Outcomes of the Group

The majority of mothers (13) reported that the group appeared to be successful in helping their children to resolve some of their anger problems. Interestingly, many of these women used the identical word to describe the changes - noting that their children seemed "calmer". Several mothers also stated that their children were expressing their anger more appropriately. The following are a selection of summaries of the mothers' comments. Please see Appendix 4 for the complete set of summaries. Although these are not direct quotations, the summaries do incorporate some of the mother's own phrasing and words:

My child is not personalizing the conflict so much anymore. Before, she used to take everything personally, she thought that mom and dad were fighting because of her. Now she knows it is nothing to do with her. She can also recognize that while the violence is wrong, there are also good things in the relationship with her dad. She's not so angry anymore. (age 13)

He's more aware of his anger and how it can be expressed. He's not destroying as many toys, not banging as many doors. He's cooperating a lot more and picking up after himself more.

My younger child, especially, is much more calm. He knows how to express himself better if he's feeling angry. He talks to me more now about how he is feeling. (age 11)

He's a lot calmer now. Before the group, he was hitting other children on a daily basis. He's still hurting kids, but much less. He's hit another child perhaps twice in the past month. He is talking more about his feelings.(age 7)

Five mothers reported that their children seemed to experience increased anger as a result of the group. While some mothers felt that this was healthy for their children, in that they were expressing feelings which they had formerly kept to themselves, others were disturbed by the increased emotion. A pattern seemed to emerge, that when there were two children in the family who attended the group, one of the children tended to get less angry, and the other more. The following again are summaries of the mothers' comments made to the researcher:

For my daughter, she's worse than when she started. My son was the one who had the anger problem - now he's much better from the group but my daughter has taken up where he left off. She's very defiant, and is angry when she doesn't get her own way. After talking with the counsellors, I realize that before she was just stuffing so much. Now she's getting stuff out of her, which is positive. She also is more in

tune now, she knows there's things she needs to work on. She not a happy-go-lucky girl anymore, though. (girl-age 8, boy-age 10)

My daughter has improved a lot and is a lot less angry. My son, though, got out of hand. He was almost suspended the other day for punching a kid. The group seemed to really increase his anger, and he's very moody now. I think it was because he was hearing all the stories from the other kids of their violent families. (girl, age 8, boy, age 9)

Six women reported that in general, their children were better at expressing their feelings, as is illustrated by the following summaries of their comments:

My daughter is more open now, she shares her feelings with me. She's started to write me notes, and is much less withdrawn. I think she's got better at sharing herself with adults. My son, I don't know if he got as much out of it as my daughter, but he's more willing to talk about his feelings. Now he'll say more about other feelings, other than just anger. (girl, age 6, boy, age 9)

Even after the first few weeks, he was much more open with me. Before, he couldn't even talk to me about his day, now he's talking a lot to me. He's also expressing his feelings more. He's handling his frustration better because he's talking more. He's still putting himself down though. (boy, age 6)

He seems more aware of a lot of his emotions. He's scared of anger though. He is afraid to get angry, and gets very upset when I yell or get upset. (boy, age 7)

He talks a lot more about his feelings now, and seems happier. (boy, age 6)

Two women were pleased because they felt that their children in general seemed a lot happier:

My oldest child was very withdrawn before. He used to spend all of his time in his room reading. Now, he seems happier. He interacts more with the rest of the family, and he's playing with his friends more. (age 14)

My child seems happier, has better attitudes at school, seems to have a higher self-esteem, is more assertive. (girl, age 12)

Three other mothers noted that their children had gained skills in self-assertion. One said that she found her child more difficult to deal with as a result of his assertiveness. Another questioned the way her daughter was using her new self-assertion. This interviewee reported that her daughter had developed an attitude of "I can handle everything", and had made some bad decisions and bad judgments for herself. The mother reported that the girl was recently involved with the police for the first time. One mother noted that her son was now challenging her more on her own behavior, saying, for instance, "Mum, you're breaking some of the rules that you set for me". She saw this assertiveness as positive, in that her son trusted her enough to say this to her.

Three women noted that their own involvement with the parenting group at the Y.W.Support Centre, coupled with their children's attendance in the group counselling program, had led to changes in their whole family system. For instance, one stated that her children were getting along much better with one another. Another said (this is a summary, and not a direct quote):

The whole family is dealing with problems better as they come up. We're talking with each other when we are upset now. Also, before we felt there was no place to go for help. Now, we know about the shelter and other places to go if we can't deal with problems on our own. Before, we felt alone in our problems.(two boys, ages 14 and 11)

Finally, two women reported that their children seemed to have an increased understanding of abuse. One said that her son often talked to her about abuse issues, which made her very pleased. Another said that her child has "got the picture now that the abuse is wrong". This mother noted that her son is also better at figuring out who is responsible for the abuse, and in knowing when to back off when he's fighting.

Summary

The demographic information collected from the mothers of children in the study revealed that a) the majority of mothers were separated or divorced, b) although many of them were working and had a reasonable level of education, the overall level of family income was low, and c) in cases where the families were separated, the children were almost always in the custody of their mothers. The mean age of the children in the sample was 7.7 years, and approximately two-thirds of the children in the sample were boys.

The mothers of the children attending the counselling groups were experiencing considerable levels of violence at the hands of their partners. Likewise, the children themselves were also witnessing and/or experiencing significant violence in their homes.

The results did not support the study's first hypothesis that child witnesses of wife abuse will report an increased level of self-esteem following their participation in a 10 week group counselling program. However, younger children (4-7 yrs) who had been physically abused, did report statistically significant improvements in their self-esteem levels following their participation in the group counselling program. The second hypothesis, that child witnesses of wife abuse will report a decreased level of anxiety following their participation in a ten-week group counselling program, was supported by the data. When the scores were separated according to age, 4-7 year old children reported a significant decrease in anxiety following the group, while the 8-14 year old children did not. An important finding was that the children reported within the normal range on the RCMAS lie scale, which also suggests that they probably responded as accurately on the self-esteem scales.

Finally, in the supplemental survey research the majority of mothers reported that their children enjoyed the groups, and they stated that their children were calmer and less angry than they were prior to their participation in the groups. A few of the mothers reported that their children's anger increased following their participation in the groups. An interesting pattern was noted in families where there were two siblings attending the groups, in that often one child's level of anger seemed to decrease following the group, while the other child's level of anger increased. Other changes amongst the children, noted by many of the mothers, included an increased ability to express feelings, increased assertiveness, a happier disposition, and an increased understanding of abuse.

CHAPTER FIVE
DISCUSSION

The purpose of the final chapter is to discuss the results of the present study, in particular, the findings that the anxiety of the children decreased significantly at post-test. Further, although no changes occurred in the self-esteem of the total sample of children between pre and post tests, the self-esteem of the young, abused children increased significantly following their participation in the group counselling. The findings that the average anxiety and self-esteem pre-test scores were within the normal range will also be discussed. Information from the supplemental telephone survey will be incorporated into the discussion where relevant. Finally, the limitations of the research, and the implications of the study's results with respect to future research and social work practice will be addressed.

Anxiety

Children in the sample reported statistically significantly less anxiety at the termination of the group counselling than before they began the program, although their pretest anxiety levels were not in the clinical range. Although it has been stressed previously that because of limitations of the research design, it is not possible to attribute changes in the variables directly to the group program with certainty, the intervention may well have been responsible at least in part for the decrease in anxiety in the children. Since no previous evaluations of group counselling programs have measured the anxiety levels of

child witnesses, the findings cannot be discussed in relation to existing literature.

Further statistical analysis showed that the significant changes in anxiety levels occurred primarily with the youngest children in the sample (ages 5-7), whereas the decreases in anxiety noted amongst the older children (ages 8-14) were not statistically significant. These results support the notion that research with children who witness violence should continue to consider age as a mediating variable (Davis & Carlson, 1987; Hughes, 1988). As discussed previously, some researchers have reported more adjustment difficulties among young child witnesses, particularly preschoolers (Hughes, 1988). While these findings may be related to measurement issues, it is also possible that preschool children (3-5 years old) are particularly vulnerable in cases of family violence because of their dependency upon adults in all aspects of life. In addition, while 6 and 7 year olds have an increased number of peer contacts, they are also still largely dependent upon adults to meet their needs (Ragg, 1991). The findings of the present research suggest that perhaps the vulnerability and dependency of younger children may mean that they are more amenable to intervention and treatment. Perhaps because they have fewer resources with which to cope (Hughes, 1988), a resource such as group counselling and support may have a greater impact upon them. Alternatively, it is also possible that the group intervention for the younger children may have been more effective than the group intervention for the older children.

Information from the telephone survey supports the notion that participation in the group counselling program contributed to decreased anxiety in the child witnesses. Many mothers used the identical word to

describe changes in their children over the course of the program - noting that their children were "calmer" after the group.

Self-Esteem

The group of children who completed the post-tests did not report significant changes in self-esteem following their participation in the group counselling. Furthermore, when asked about changes they had noticed in their children following the group counselling, only two mothers in the telephone survey mentioned that they felt their children's self-esteem had improved.

One possible explanation for this is that child witnesses may not perceive problems with their self-esteem in the first place, and therefore, would be unlikely to report changes on this variable as a result of group intervention. In fact, the pre-test self-esteem scores of the child witnesses in the present study were within the normal range. As has been mentioned previously, there has been little empirical research investigating the extent to which child witnesses of violence see themselves as suffering from poor self-esteem.

The lack of changes in self-esteem among the participants in the current study is an important finding. There have been no previous evaluations of children's group counselling programs in which self-esteem has been investigated with the use of self-report measures. The only two studies in the literature which have reported an association between increases in self-esteem among child witnesses and their participation in group counselling programs relied upon different ways of measuring self-esteem. For instance, the findings of Gruszsnki et al. (1988), in which they reported that the group increased the children's self-esteem, were based upon clinical rating scales

completed by the group leaders. Peled and Edleson's (1992) study, in which a similar conclusion was drawn, was a qualitative evaluation.

Despite the lingering question about whether or not self-esteem is a pertinent variable for child witnesses of violence, and despite the lack of changes in the total sample of children on this variable between pre and post-tests, there were, nevertheless, some noteworthy findings in the present study with respect to the younger children. The 4-7 year old children who had been physically abused, did report significantly improved self-esteem at post-test ($p<.04$). Based upon their research, several authors have suggested that children who are both witnesses and victims of abuse are subject to a "double whammy", and have the most adjustment difficulties (Hughes, 1988; Davis & Carlson, 1987). Considering that, as previously discussed, being young may also be a risk factor for maladjustment in the witnessing of interparental violence, the young, abused witnesses in the sample certainly could be considered a vulnerable sub-group. Their significant improvements in self-concept again raise the possibility that the group intervention had the greatest impact upon the most vulnerable children in the sample.

Child Witnesses' Anxiety and Self-esteem Scores in Comparison to Normative Data

The fact that the self-reported anxiety and self-esteem scores of the children were within the normal range at pre-test was surprising. As has been previously mentioned, it may be that children simply do not perceive themselves as experiencing low levels of self-esteem or high levels of anxiety. Nonetheless, in the eyes of others, they may seen as exhibiting such problems.

In fact, some researchers working with sexually abused children have recently reported that self-report measures were of limited value in assessing problems areas and/or therapeutic change (Mannarino, Cohen, Smith & Moore-Motily, 1991; Hiebert-Murphy, DeLuca, & Runtz, 1992). In these studies, the parent-reported data typically indicated that their sexually abused children were experiencing significant symptomatology. In contrast, the findings from the self-reported self-esteem and anxiety measures were largely insignificant.

In a similar manner, the mothers' comments from the telephone survey indicated that the child witnesses who attended the counselling groups were experiencing considerable adjustment difficulties. The majority of the mothers stated that they had sought help because the children expressed high levels of anger, and were having difficulties controlling this anger. The examples cited previously, such as the six year old boy who was hitting other children at school on a daily basis, or the child who was having violent rages in his classroom, are illustrative of this point.

With respect to the self-report data, it may be that children lack the maturity to accurately rate their feelings and attitudes, a necessary requirement of self-report instruments (Beitchman & Corradini, 1988). Furthermore, children may tend to respond to questions based upon their immediate circumstances, rather than upon their more stable experiences. They may also be, "unable or unwilling to report on important aspects of their dysfunction" (Beitchman & Corradini, 1988, p. 486). A final point is that parents and children differ in the type of information they can immediately appraise (Herjanic & Reich, 1982, cited in Beitchman & Corradini, 1988).

Research evaluating intervention programs would, thus, be enhanced by including data from a variety of sources such as children, parents, and teachers.

The Impact of Community-based Group Counselling Programs upon Child Witnesses

There is still relatively little research evaluating group counselling programs for children who are witnesses of interparental violence. In an effort to gain a preliminary understanding of the impact of the programs upon child witnesses, and to generate hypotheses for further research, most of the studies carried out to date have been exploratory in nature. To the writer's knowledge, there have only been five evaluations of group programs conducted, and only one of these utilized an experimental research design. As such, many of the conclusions drawn so far about the impact of such programs can only be considered as tentative. The most convincing evidence of the benefits of group counselling programs comes from the work of Wagar (1991) who used the only rigorous design, employing random assignment and a waiting list control group to measure pre and post changes amongst group participants. Her findings, which have been previously stated, were that the children in the groups reported significantly greater changes than the control group in their attitudes and responses to anger, as well as in their knowledge of support and safety skills. As has been discussed in detail elsewhere, the findings from other research studies have included suggestions that the program is associated with the children's increased positive perception of their parents, with an increase in their self-esteem, and with the development of new, nonviolent ways of solving problems (Jaffe et al., 1988; Grusznski et al., 1988). It is also thought that the

group counselling program enables children to break the secret of family violence, to increase their emotional expressiveness, to release pent-up feelings, and to discover that they are not the only ones who live in conflictual, violent homes (Peled & Edleson, 1992). Some of the researchers have reported that the group helped children to decrease their sense of responsibility for the violence, however others, including Wagar (1991), found no change on this variable.

The present study, which is also exploratory in nature, adds to the presently small body of knowledge in suggesting that there may be an association between the group program and a reduction in self-reported anxiety amongst the participants, as well as an increase in self-esteem amongst young abused witnesses. The present research also highlights the importance of age and abuse status as mediating variables in evaluating the impact of group counselling upon child witnesses. Clearly though, there is a need for further research on the impact of group counselling upon child witnesses.

Limitations and Strengths of the Study

As mentioned previously, the lack of a control group in the present study means that one must be cautious in interpreting the results. Although the data from both the standardized measures and the telephone survey suggest that the group intervention may have had a positive impact upon the children, it is not possible to state definitively that the changes in the anxiety and self-esteem were due to the group intervention, since changes in the children may have been a result of other unknown variables. Had there been a waiting list

control group, it is possible that these children may also have reported significant decreases in their anxiety.

The significant increase in self-esteem among young, abused child witnesses was noteworthy, but must be treated cautiously because the reliability and validity of the McDaniel-Piers scale has not been firmly established.

Despite these limitations, the study nevertheless contributes to our understanding of the impact of group counselling on child witnesses. To the writer's knowledge, it is the first study to have used self-reported, standardized measures to evaluate a group counselling program with this population. While the use of self-report measures with traumatized children may have some drawbacks, such as their possible difficulties in accurately portraying their feelings, beliefs, or aspects of their dysfunction, outcomes from the use of these measures certainly merit consideration. Furthermore, the observations of the mothers in the telephone survey enhanced the interpretation of the quantitative findings, allowing for comparison between the data obtained from the self-reports and the mothers' reports.

Implications for Further Research

Previous research has suggested that children adjust differently to interparental violence, according to their gender, age, and whether or not they were abused themselves. Although gender was not a mediating variable in the present study, the results did suggest that age and abuse status were important mediating variables. The present study, thus, supports the

continued need to take into consideration children's abuse status and age in future evaluations.

The comments made by mothers in the telephone survey added depth to the study, and both contrasted and supported the data from the standardized measures. The study would have been further strengthened by the administration of parent-reported standardized measures, such as the Achenbach Child Behavior Checklist, since a number of authors have asserted that effective assessments of traumatized children must include data obtained from a number of informants (Jaffe et al., 1990; Beitchman & Corradini, 1988).

The results of the study failed to show any statistically significant improvements in self-esteem among the children, except for those 4-7 year olds who were physically and emotionally abused. However, given that the mothers reported some positive changes in their children such an increased emotional expressiveness, a recommendation for further research would be to carry out longitudinal studies of these children, in order to explore whether the group may have had some long term impact upon variables such as self-esteem. Gander and Gardiner (1981) have noted that "self-concept does not develop all at once", but rather, "emerges out of interaction with other people or internal dialogue with our own feelings and ideas" (p. 422). In fact, many of the mothers in the telephone survey stated that their children would be attending the second stage children's group at the Y.W. Support Centre. This follow-up program for those children who have 'graduated' from the first ten week counselling group presents an ideal opportunity to measure the impact of the program over a longer term. For instance, measures could be administered to

children prior to their participation in the first group, and then again following their participation in the second stage group.

One of the questions posed by Wagar (1991) in her evaluation of a group counselling program was whether or not the effectiveness of the program would increase if the parents of the children attended a parenting group at the same time. When she evaluated the group counselling program for child witnesses, no such program for parents existed. However, at the time of the present evaluation, a parenting group was offered concurrently with the children's group, and many of the mothers with whom the researcher spoke had attended this group. It would have been interesting to assess whether or not the parents' attendance in counselling was an important mediating variable in terms of the children's improvement. Several authors have suggested that children's programming is more effective if it occurs in the context of a comprehensive array of interventions with the victims/survivors and perpetrators (Peled & Edleson, 1992; Hurley & Jaffe, 1990).

Some of the comments made by mothers in the telephone interviews were insightful and powerful, and warranted further exploration. However, because the researcher was administering a structured survey, it was not possible to obtain very detailed information. Future research using a qualitative design, however, might provide some in-depth data about the impact of the counselling program upon children. Peled and Edleson's (1992) qualitative evaluation of a ten week counselling program produced some interesting and detailed data about both the intended and the unintended outcomes of the group program. The authors, therefore, called for the inclusion of qualitative methodology in future program evaluations.

Finally, the use of a comparison group in future research would strengthen the research design, and provide an opportunity to contrast the adjustment of child witnesses in the groups with child witnesses who did not receive any intervention.

Implications for Social Work Practice

The present study joins the few other evaluations of counselling groups for child witnesses in suggesting that the groups may be helpful in ameliorating some of the effects upon children of witnessing violence. With respect to social work practice, then, the evidence is mounting in favour of group intervention for children as an important aspect of social work practice with violent families.

If further research can support the findings of the present study and demonstrate that the group does, in fact, contribute towards reduced anxiety in child witnesses, then the program should be seen as a valuable resource for practitioners working in a variety of social work settings. Anxiety is an unpleasant emotion which can interfere with all aspects of daily living, and can "disrupt normal thought processes" (Reynolds & Richmond, 1985. p.3). For example, some of the concentration difficulties that children experience in school may be related to the violence they are witnessing at home. Other manifestations of anxiety in children, such as insomnia, nightmares, and excessive worrying might also be traced to violence between the parents. These symptoms often come to the attention of practitioners working in social work agencies such as family service centres and child welfare units. If research can demonstrate that group counselling does help to reduce children's

anxiety, then a referral to the program may assist children with such symptoms.

The results of the present study suggest that it is possible that the intervention may have had the greatest impact upon the most vulnerable children in the sample - the young children (5-7 years of age), and the young children who had also been physically abused themselves. Although these findings can only be considered tentatively, if they are valid and can be confirmed by further research, the implications for social work practice are that interventions with child witnesses of violence should begin at an early age - perhaps even with preschoolers. Group facilitators may also want to know which young children in their groups have also been abused, since the results of the present study suggest that the intervention may have a particularly powerful effect upon them.

Despite the lack of changes in self-esteem reported by most of the study's participants, according to the mothers, many children made some important gains in their awareness and expression of feelings, and in communicating with others. The mothers also suggested that the program seemed to help children to express their anger in more appropriate ways, and to reduce their aggressive tendencies. From a social work perspective, helping clients to gain an increased understanding and expression of feelings is a cornerstone of the counselling process. Ivey (1988) notes that, since, "out of emotions spring many of our thoughts and actions...if we can identify and sort out clients' feelings, we have a foundation for further action" (p. 112).

Conclusions

In an academic, quantitative study such as this, it is easy to focus so much upon the statistics and the research that one forgets the human faces behind the data - all of the many children who completed the questionnaires, and who were making valiant attempts to cope with the violence in their lives. A selection of summaries of the mothers' comments attests to the impact of the group counselling, and speaks more powerfully than the statistics:

My son is not the same person now. His attitude is much better. He's very polite, more cooperative, and a lot more willing to talk. He hasn't yet learned appropriate ways of dealing with anger, but his outbursts are not as frequent now. They used to be once a week, now they are once a month. He's also not as physical as he was before the group. He's communicating better.

My eldest child has calmed down a lot. The group gave him different suggestions as to how to handle anger. If he's angry at me, he'll take 20 minutes to calm down and then he'll come back and talk to me.

My daughter has improved a lot, and is a lot less angry. The group helped my kids to feel like they weren't the only ones having family problems. I think the group helped her to understand me more, and she's learning to adjust to the fact that the family won't be re-uniting.

He's not as ready to scream when things go wrong. He's speaking more clearly, and saying what's upsetting him. Before, he could barely get the words out. He's less out of control when he's angry.

Intervening with children from violent homes fits within the realm of prevention, and is, therefore, a highly desirable type of social work intervention. A general concensus now exists in the literature that, "children who witness violence are not only more disturbed in their interpersonal relationships than other children, but are at significant risk to repeat the dysfunctional relationship patterns that they have learned in their family of origin with their future spouses" (Hurley & Jaffe, 1990, p. 472). Furthermore, some of the most horrific episodes of violence in our society have been perpetrated by men who grew up in violent homes. The upbringing of Mark Lepine, who murdered 14 women in Montreal in 1989, was marked by violence and abuse (Moore et al., 1990). We can all hope that concentrated efforts aimed at helping children and their families to learn alternatives to violence might ultimately result in a less violent society in the future.

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APPENDIX I
CONSENT FORM

To all mothers of children attending groups at the Support Centre:

Hello. I am a graduate student in the Faculty of Social Work at the University of Calgary. I would like your help in a study that I am conducting to find out how valuable the Support Centre group is for your child(ren). In order to do this, I would like to talk with you for about ten or fifteen minutes over the phone, after the groups are over and at a date and a time that is convenient to you. In general, I will be asking you questions about what you think your child has gained from the group, and any suggestions you might have for future children's groups at the Y.W. Support Centre.

If you would be willing to participate in this short interview, please sign the form below.

Thanks, and I look forward to talking with you.
Gill Cox
MSW Candidate
University of Calgary

* * * * * * * * * * * *

I agree to participate in the evaluation of the Y.W. Support Centre's groups for children, to be completed by Gill Cox, MSW Candidate in the Faculty of Social Work, University of Calgary.

I understand that I will be interviewed over the phone by Gill. All responses will be kept completely confidential, subject to the provisions of the Child Welfare Act, which requires everyone to report to Child Welfare any case in which the child is in need of protection. Any identifying information will be removed from the notes taken during the interview. These notes will be kept in a locked office at the University of Calgary and will be destroyed within one year - at the end of the research project. Further, I realize that I can refuse to answer any questions and that I may withdraw from the research at any time, without affecting my participation in the Y.W. Support Centre programs in any way.

Date _____

Name _____

Signature _____

APPENDIX II

TELEPHONE SURVEY

1. How did you hear about the Y.W.S.C.'s children's groups?

2. What were your reasons for deciding to enroll your child(ren) in the groups at the Y.W.S.C.?

3. What did you initially expect your child(ren) to gain from the group?

4. Was the purpose of the group explained clearly to you, so that you knew what to expect from the group?

5. What do you think your child(ren) expected to gain from the group?

6. How do you think your child(ren) reacted to the group?

7. Have you noticed any changes in your child(ren)'s attitudes, feelings. or behavior since the beginning of the group? (If so, what kinds of changes)

8. What do you think were the strengths of the program?

9. Do you have any suggestions for improving the program?

10. Were your expectations of the group met?

11. Do you think your child(ren)'s expectations were met?

12. Do you have continued concerns about your child(ren) that you may need help with again in the future? If so, what kinds of concerns, and what might be helpful?

13. Did the Y.W.S.C. give you some names of other places you can go to for help in the community?

APPENDIX III

YWCA SUPPORT CENTRE
...alternatives to domestic abuse

INFORMATION AND PERMISSION FORM (PARENT)

A group counselling program for children (aged 5-15) who have been exposed to serious family conflicts (such as domestic abuse) is provided by the YWCA Support Centre. The counselling program consists of 10 group sessions each lasting approximately 1 and 1/2 hours. The sessions 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 included.

In order to determine how valuable this group was for the participants, the parent(s) and the participants are asked to complete questionnaires before and after group participation. In addition, the participants level of anxiety and self-concept will be measured. The parent(s) will receive some individual feedback about their child after the group is terminated.

Your participation is completely voluntary, and you are free to withdraw from the program at any time. All information obtained will remain confidential subject to provisions of the Child Welfare Act, which requires everyone to report to Child Welfare any case in which the child is in need of protection. To further assist the Centre's work with your child(ren) their teacher will be contacted to fill out a form with their impressions of your child(ren) at school. All identifying information will be destroyed once the data has been gathered. If you have any questions, please feel free to inquire.

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

Name: _____ Signature:_____

Phone: _____ Date: _____

Names of Children: _____

Witness: _____ Date: _____

Name of School: _____

Address of School: _____

Name of Primary Teacher:_____

APPENDIX IV

SUMMARIES OF MOTHER'S COMMENTS PERTAINING TO THE OUTCOMES OF THE GROUP COUNSELLING PROGRAM

1. Positive changes noted by mothers in regards to the children's anger:

My child is not personalizing the conflict so much anymore. Before, she used to take everything personally, she thought that mom and dad were fighting because of her. Now she knows it is nothing to do with her. She can also recognize that while the violence is wrong, there are also good things in the relationship with her dad. She's not so angry anymore. (age 13)

He's a bit calmer, and is learning to accept and talk about his feelings more. He will say "'please don't do it'", rather than screaming and yelling. He is a little easier to talk to. (age 5)

My younger child, especially, is much more calm. He knows how to express himself better if he's feeling angry. He talks to me more now about how he is feeling. (age 11)

My eldest child has calmed down a lot. The group gave him different suggestions as to how to handle anger. If he's angry at me, he'll take 20 minutes to calm down and then he'll come back and talk with me.(age 12)

He's a lot calmer now. Before the group, he was hitting other children on a daily basis. He's still hurting kids, but much less. He's hit another child perhaps twice in the past month. He is talking more about his feelings.(age 7)

My daughter has improved a lot, and is a lot less angry. The group helped my kids to feel like they weren't the only ones having family problems. I think the group helped her to understand me more, and she's learning to adjust to the fact that the family won't be re-uniting. (age 8)

He's more aware of his anger and how it can be expressed. He's not destroying as many toys, not banging as many doors. He's cooperating a lot more and picking up after himself more. (age 6)

He's not as ready to scream when things go wrong. He's speaking more clearly, and saying what's upsetting him. Before, he could barely get the words out. He's less out of control when he's angry. (age 9)

My son is not the same person now. His attitude is much better. He's very polite, more cooperative, and a lot more willing to talk. He hasn't yet learned appropriate ways of dealing with anger, but his outbursts are not as frequent now. They used to be once a week, now they are once a month. He's also not as physical as he was before the group. He's communicating better. He's not as mouthy as he was before - before he mouthed off to me every day. Now it's about once a month that he'll do that. (age 10)

2. Changes where mothers reported increased anger in their children (note the tendency for siblings to differ in their responses to the group):

For my daughter, she's worse than when she started. My son was the one who had the anger problem - now he's much better from the group but my daughter has taken up where he left off. She's very defiant, and is angry when she doesn't get her own way. After talking

with the counsellors, I realize that before she was just stuffing so much. Now she's getting stuff out of her, which is positive. She also is more in tune now, she knows there's things she needs to work on. She not a happy-go-lucky girl anymore, though. (girl-age 8, boy-age 10)

My oldest child is much calmer, but my youngest has been getting progressively more angry. Mind you, he was closer to my husband, so he may be more affected by our divorce. (older boy-age 12, younger boy-age 9)

My daughter has improved a lot and is a lot less angry. My son, though, got out of hand. He was almost suspended the other day for punching a kid. The group seemed to really increase his anger, and he's very moody now. I think it was because he was hearing all the stories from the other kids of their violent families. (girl, age 8, boy, age 9)

He went through a phase where he was nasty. He used what he learned to his own advantage. For example, he announced one day "I'm not vacuuming anymore. I don't have to do anything I don't want to do". Before, he was so easy-going and cooperative. He's starting to be more cooperative again though. I think he must have stuffed his anger before, and now it's all coming out. (age 6)

My two kids used to be passive before. Now, they are both very aggressive, much more than before. They throw stuff, and pinch each other. They're going to play therapy now. I think they're angry now, but they don't know how to express it. My daughter has been talking a lot more, though.(girl, age 6, boy, age 8)

3. Positive changes reported by mothers in regards to the general expression of feelings:

We're not an expressive family overall, but I think he's starting to verbalize his feelings more. I didn't really know him that well before, because I was too stressed out by being abused. (age 6)

My daughter is more open now, she shares her feelings with me. She's started to write me notes, and is much less withdrawn. I think she's got better at sharing herself with adults. My son, I don't know if he got as much out of it as my daughter, but he's more willing to talk about his feelings. Now he'll say more about other feelings, other than just anger. (girl, age 6, boy, age 9)

Even after the first few weeks, he was much more open with me. Before, he couldn't even talk to me about his day, now he's talking a lot to me. He's also expressing his feelings more. He's handling his frustration better because he's talking more. He's still putting himself down though. (boy, age 6)

He seems more aware of a lot of his emotions. He's scared of anger though. He is afraid to get angry, and gets very upset when I yell or get upset. (boy, age 7)

He talks a lot more about his feelings now, and seems happier. (boy, age 6)

For my youngest child, I think the group helped her to dissect her feelings, and understand them more. I think after the first few sessions, she had a lot of feelings she wasn't expressing. I encouraged

her to talk about what was bothering her, and she did a lot of crying about other children's stories. (age 8)

My oldest child was very withdrawn before. He used to spend all of his time in his room reading. Now, he seems happier. He interacts more with the rest of the family, and he's playing with his friends more. (age 14)

My child seems happier, has better attitudes at school, seems to have a higher self-esteem, is more assertive. (girl, age 12)