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An Examination of Affective, Behavioural, and Knowledge Variables in Children Exposed to Marital Violence

by

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A THESIS

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Abstract

The primary purpose of this study was to describe the functioning and well-being of a sample of children exposed to marital violence at two points in time. Participants were 47 children, aged 6-12, enrolled in a 10-week group treatment intervention. Measures were administered prior to the commencement of the program and again in the ninth week of the intervention. Children completed self-report measures of anxiety, depression, posttraumatic stress symptoms, and knowledge of abuse and safety planning. Parents reported on child competence and behaviour problems, as well as their own experience of stress. Results indicated elevated rates of clinical scores on several measures compared with normative data. Parental stress was significantly correlated with reported child behaviour problems, anxiety, depression, and posttraumatic stress symptoms. Scores at the second assessment indicated significant changes in child behaviour problems, parental stress, and child knowledge. Mediating factors of gender and child physical abuse were examined.

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Table of Contents

List of Tables

CHAPTER ONE: INTRODUCTION

An increased awareness of marital violence in the last two decades has led to an exploration of the impact of this form of parental interaction on children in the home. Preliminary reports of detrimental effects by Levine (1975) and Moore (1975) led to a surge of descriptive and empirical studies in the 1980's assessing the well-being of children exposed to spousal violence (for example, Davis & Carlson, 1987; Hughes & Barad, 1983; Hughes, 1988; Jaffe, Wolfe, Wilson, and Zak, 1986b). Despite continued research efforts focusing on children living in homes characterized by marital violence, numerous authors have noted that this issue continues to receive insufficient attention (Hughes & Fantuzzo, 1994; Holden, 1998).

A few studies have documented intervention efforts and evaluations of treatment programs with children exposed to marital violence (for example, Jaffe, Wilson, & Wolfe 1988; Wagar & Rodway, 1995). Recent research efforts to gain understanding of the impact of marital violence have expanded and begun to investigate posttraumatic stress symptoms in this population of children (Graham-Bermann & Levendosky, 1998a; Kilpatrick & Williams, 1998; Lehmann, 1997). Inherent methodological challenges and equivocal findings have hampered efforts in all areas of research with children living with spousal abuse (Kolbo, Blakely, Englemen, 1996; McDonald & Jouriles, 1991).

Several researchers have suggested that the deleterious impact of interparental violence on children may be best conceptualized as a form of emotional or psychological abuse (Barnett, Miller-Perrin, & Perrin, 1997; Cummings, 1998; Hughes & Fantuzzo, 1994; Peled & Davis, 1995). This postulation is particularly disturbing when the

prevalence of marital violence is taken into account. The 1999 General Social Survey (GSS) on Victimization in Canada estimated that 7% of people who were married or living in a common-law relationship had experienced some type of violence by a partner during the previous 5 years (Statistics Canada, 2000). Women and men in Alberta reported one of the highest rates of spousal abuse in the country (11% and 9% respectively) over the 5-year period (Statistics Canada, 2000). The GSS found that the rate of reported violence was similar for women and men (8% and 7% respectively). However, this survey also noted that women were abused more severely than men. For example, women were five times more likely to receive medical attention and five times more likely to fear for their lives (Statistics Canada, 2000). Therefore, the differences in outcome and consequences of abuse at the hands of men and women is not necessarily in regards to reported incidence, but in regards to the severity and impact of the violence.

Thirty-seven percent of spousal violence victims in the GSS reported that children had heard or seen violence in the home. That figure translates into "approximately half a million children have heard or witnessed a parent being assaulted during the 5-year period" (Statistics Canada, 2000, p. 5). Children in violent households were often exposed to severe acts of violence. In 53% of cases where a child had witnessed a violent incident towards their mother, the woman had also reported that she had feared for her life at some point in the previous five years. As well, children in homes where mothers reported having been physically injured were found to be twice as likely to witness violence (Statistics Canada, 2000). The data presented here relied on parental reports of whether their children "witnessed" violence.

Holden (1998) highlighted the value of referring to children "exposed" to marital violence rather than using the terms "witnesses" or "observers" of violence which may be misleading. By utilizing the term "exposed", all children living in homes characterized by spousal abuse are included and this phrase acknowledges that children may be affected by marital violence in ways other than directly witnessing violence. For example, children may overhear a parental assault, see the resulting injuries, or experience the resulting interactions between their parents (Barnett et al, 1997; Graham-Bermann, 1998; Health Canada, 1999; Holden, 1998; Jaffe, Wolfe, and Wilson, 1990).

Utilizing a more inclusive term to refer to children's experience of marital violence avoids value judgments about what constitutes "witnessing" (Fantuzzo & Mohr, 1999). The term "exposed" also removes the need to rely on reports by parents who may deny, underreport, or simply be unaware of the amount or type of exposure their child has had to incidents of violence in the marriage (Holden, 1998). As well, considerable disagreement has been discovered between parents in regards to whether their child witnessed or overheard interspousal aggression (O'Brien, John, Margolin, and Erel, 1994).

Another issue of terminology which has created confusion in the literature is the way in which the violence occurring between the adults in a child's home has been referred to (Holden, 1998). The term "domestic violence" has been widely utilized in this regard; however, it does not exclusively refer to the issues at hand, as it may include other concerns, such as child physical abuse. Another common term in the literature is "wife abuse", however, this term does not encompass abuse that is perpetrated towards

husbands or the existence of interactional violence between spouses. Therefore, this investigation refers to children exposed to "marital", "interparental", or "spousal" violence and abuse.

The present study examined affective, behavioural, and knowledge variables in a sample of children exposed to marital violence. Children in this sample accessed a 10-week group treatment intervention, and their parents were provided with a coinciding parenting program. The primary purpose of this study was to describe the functioning and well-being of this sample in relation to normative data and to examine shifts in measures between the pre- and post-intervention assessment periods. A relatively new instrument for assessing posttraumatic stress and associated symptoms in children was utilized in conjunction with standardized measures of children's depression, anxiety, and behaviour. Children's knowledge was assessed in terms of their understanding of abuse variables and safety planning ideas. Numerous mediating variables were examined, including: child gender, child physical abuse, and parental stress.

CHAPTER TWO: REVIEW OF THE LITERATURE

The Impact of Marital Violence on Children

As previously noted, several authors have suggested that a child's exposure to interspousal violence may be viewed as emotionally or psychologically abusive (Barnett et al., 1997; Cummings, 1998; Hughes & Fantuzzo, 1994; Peled & Davis, 1995). "Although the use of the word *abuse* may be questioned, exposure to marital violence is at the very least a significant source of adversity that contributes to children's risk for the development of psychopathology" (Cummings, 1998, p. 56). Barnett et al. (1997) note the numerous threats faced by children exposed to marital violence, including: fear for self, fear for mother, feelings of helplessness, self-blame, as well as a likelihood of experiencing other forms of abuse.

Children who are exposed to marital violence have been shown to exhibit adjustment problems similar to those of victims of direct physical child abuse (Holden & Ritchie, 1991; Hughes & Fantuzzo, 1994; Jaffe, Wolfe, Wilson, & Zak, 1986a). Even rare instances of exposure to interparental violence can be profound, and the adverse effects may be persistent over time. "For example, exposure to acts of marital violence may threaten and undermine children's sense of the predictability and warmth within the family, causing children to worry, be chronically aroused, and feel threatened and emotionally distressed" (Cummings, 1998, p. 69).

Despite numerous findings of detriments to children's well-being, it is important to remember that this population is extremely heterogeneous. Children who live in maritally violent homes are at risk for a wide variety of problems affecting several

different domains of functioning, including emotional, behavioural, social, cognitive, and physical (Holden, 1998; Kolbo et al., 1996; Pelcovitz & Kaplan, 1994). Barnett et al., (1997) note that there is "extreme variability in outcomes" in this population, including a proportion of children who appear to have no adverse effects from exposure to marital violence (p. 146). The current literature on the impact of interparental violence on school-aged, preadolescent children is reviewed in regards to emotional and behavioural concerns, posttraumatic stress symptoms, and cognitive and attitudinal factors.

Emotional and Behavioural Concerns

Moore (1975) provided one of the first articles addressing the well-being of children in homes characterized by marital violence with an overview of 23 case studies provided through a social service agency in England. Levine (1975) examined the impact of interparental violence on children in 50 families he had seen as a doctor in general practice. Each of these articles identified a variety of concerns regarding the children in these environments, including somatic concerns, anxiety, school problems, child physical abuse, and truancy. These studies called for further research into the impact of marital violence and suggested direct intervention with this population of children.

These initial investigations led researchers to begin examining the well-being of children residing in shelters for battered women. For example, Hughes and Barad (1983) examined variables of self-concept, anxiety, and problem behaviour in 65 children, aged 3- to 13-years, living in a shelter with their mothers. Overall, childrens' levels of functioning measured in self-concept, anxiety, and problem behaviour were found to be similar to that of normative data. Gender differences were found for parent ratings of

problem behaviours in school-age children. School-aged boys in this sample were rated by staff at the shelter as having higher total problem scores and rated by their parents as having higher scores of aggressive behaviour compared to normative data.

Jaffe, Wolfe, Wilson, and Zak (1985) studied 50 children and mothers residing in a shelter for abused women and 50 children and mothers from non-violent families in the community. Boys from violent homes were reported by their parents to have significantly more behaviour problems compared to children from the non-violent homes. No significant differences were reported for girls from violent homes. This study concluded that child behaviour problems were strongly associated with maternal factors and the amount of physical aggression in the home. In a similar study, Wolfe, Jaffe, Wilson, and Zak (1985) investigated behaviour problems and social competence according to the Child Behaviour Checklist (CBCL) with children aged 4 to 16 from shelters for abused women (n=102) and from non-violent families in the community (n=96). The children of battered women were rated by their mothers to be significantly higher in terms of behaviour problems and significantly lower in social competence compared to the community group. A gender difference was evident, as 34% of the boys and 20% of the girls from the shelter group fell within the clinical range for behaviour problem scores.

Children scoring in the clinical range in this sample were more likely to have been exposed to a higher frequency of violence and to have experienced more negative life events compared to their peers who were rated as displaying fewer problems. Taken together, family violence variables and ratings of maternal stress were discovered to

account for 19% of the variance in child behaviour problems and 16% of the variance in social competence in this sample. Wolfe et al. (1985) noted that the families in the shelters had significantly more changes in residence, more marital separations, and more contacts with mental health services than the comparison group from non-violent families in the community.

Jaffe et al., (1986b) compared maternal ratings of social competence and behaviour problems on the CBCL with children aged 6- to 11-years old from violent (n=58) and nonviolent homes (n=68). Girls from violent families were shown to have significantly more Internalizing behaviour problems and lower levels of social competence than the comparison group. In relation to the nonviolent comparison group, boys from violent families were reported to have significantly higher levels of Internalizing and Externalizing concerns, as well as having lower levels of social competence. In this study a significant positive correlation was found between the total behaviour problems score on the CBCL and the amount of marital violence reported by the mother.

Christopoulos, Cohn, Shaw, Joyce, Sullivan-Hanson, Kraft, and Emery (1987) compared the individual and familial adjustment of 40 battered women and their children, aged 5 to 13, with a sample of 40 community families with similar socioeconomic backgrounds. The most significant difference identified in this study was the increased levels of distress in the battered women as compared to those women from the community. The children of battered women were found to have elevated Internalizing and Externalizing behaviour problem scores on the CBCL compared to normative data.

However, in this study the sample of community boys also had elevated behaviour problem scores and significant differences between the two groups were only found in terms of Internalizing and Externalizing behaviour problems for girls.

A particularly large study (N=185) was conducted by O'Keefe (1994b) with an ethnically diverse sample of children, aged 7- to 13-years old, living with their mothers at a shelter for battered women. Parents' reports on the CBCL indicated that this sample differed greatly from norms for the general population. In fact, a significant proportion of the children were experiencing problems in the clinical range for Externalizing problems (45% of the sample) and Internalizing problems (57% of the sample). Younger children in this sample were found to exhibit significantly more Externalizing behaviour problems compared to the older children. O'Keefe (1994b) suggested that this finding may be due to an inferior ability to understand the violence and to mobilize coping resources. No gender differences were evident in this sample, as boys and girls were at high risk for developing Internalizing and Externalizing concerns.

The amount of marital violence witnessed by the children in this sample was significantly related to their adjustment. This finding held true even when other factors, such as direct violence to the child, were controlled. O'Keefe (1994b) highlighted five variables that were significantly correlated with both Internalizing and Externalizing behaviour problems in this sample and that may have played a role in mediating the negative impact of exposure to marital violence. These factors were: child temperament and emotionality, the amount of violence witnessed, the amount of mother-child violence,

the mother's perception of the father-child relationship, and the total number of social supports reported.

The majority of investigations have focused primarily on parents' reports of behaviour problems and social competence reported by the mother, however, some studies have explored other concerns. For example, a study by Graham-Bermann (1996) assessed the anxieties of 7- to 12-year-old children in families with (n=60) and without marital violence (n=61). On the CBCL, boys from violent families were found to have more Internalizing behaviour problem symptoms than did girls from violent families and all children from non-violent families. Children in families with domestic violence were found to be significantly more concerned about the vulnerability of their family members than the comparison group. "These findings suggest that the impact of domestic violence on children includes heightened worry about the safety of family members, in addition to and/or underlying their often-reported behavioural adjustment problems" (Graham-Bermann, 1996, p. 286).

There have also been some attempts to investigate functioning of children after they have left shelters. For example, Wolfe, Zak, Wilson, and Jaffe (1986) examined adjustment in children, aged 4- to 13-years old, currently residing in a shelter for battered women (n=17), children who had formally resided in a shelter for battered women (n=23), and a non-violent control group (n=23). Children recently exposed to marital violence (i.e. current residents of the shelter for battered women) were reported to have lower levels of social competence than the other two groups of children. No significant differences were found between the three groups in terms of behaviour problems in this

sample. Wolfe et al. (1986) suggested that this finding is due, at least in part, to the small sample size, as trends were evident for children from violent families, particularly those currently residing in shelters, to have higher levels of Internalizing and Externalizing problem scores. Wolfe et al. (1986) discussed the possibility that the lack of differentiation between the former residents and the control group may indicate that there is hope that once families have eliminated violence in the home, some form of "recovery" may occur (p. 102).

Kolbo et al. (1996) reviewed the empirical literature on the well-being of children exposed to marital violence and concluded that as methodological variables are improving (i.e. the use of standardized measures), the previously equivocal findings regarding children's emotional and behavioural concerns are becoming increasingly congruent. For example, even when significant differences were not discovered between children exposed to marital violence and comparison groups (i.e. Christopoulos et al., 1987), the scores of children living with interparental violence were comparable to similar samples and are still significantly elevated compared to normative data. Thus, the lack of significant differences between the two groups may be attributable to elevated scores in most comparison groups or in normative data. Another common finding has been the association between the level of concern evident in the child and the amount or degree of violence the child has been exposed to (Jaffe et al., 1986b; O'Keefe, 1994b).

Although differences in sampling and assessment procedures contribute to the confusion regarding outcomes for children exposed to marital violence, this population is clearly at an increased risk, according to maternal reports of behaviour problems.

McDonald & Jouriles (1991) concluded that clinical levels of concern for behaviour problems are generally evident in 25% to 70% of children exposed to marital violence samples. Holden (1998) indicated that the median percentage of children reaching the clinical level of behaviour problems is about 40%, which is significantly higher than the rates for comparison groups (approximately 10%).

Posttraumatic Stress Symptoms

A DSM-IV-TR diagnosis of Posttraumatic Stress Disorder (PTSD) includes the persistence of the following three criteria for more than one month: re-experiencing of traumatic event(s), avoidance of stimuli associated with the trauma, and increased levels of arousal (American Psychiatric Association, 2000). The DSM-IV-TR diagnostic information for PTSD specifies that a traumatic stressor may involve "witnessing an event that involves death, injury, or a threat to the physical integrity of another person" (American Psychiatric Association, 2000, p. 463). The DSM-IV-TR also states that severity and/or chronicity of PTSD may increase if the precipitating trauma is perpetrated by another human being. Pelcovitz and Kaplan (1996) noted that spousal abuse includes two main components of PTSD risk: threat to life and unpredictability. "Because the pattern that typically accompanies spouse abuse includes periods of relative calm followed by unpredictable violent outbursts, child-witnesses frequently encounter situations in which it is difficult to predict when violent incidents will erupt" (Pelcovitz and Kaplan,1996, p.457). It seems clear that children exposed to marital violence may be at risk for developing symptoms of Posttraumatic Stress Disorder. "The chronicity, terror, and unpredicitibility of witnessing mother assault coupled with the children's

perceptions that they are not able to contain or stop the violence (e.g., self-blame/guilt, personal vulnerability, and seeing the world as dangerous) may exacerbate symptoms of PTSD" (Lehmann, 1997, p. 244).

Graham-Bermann and Levendosky (1998a) noted that children from homes characterized by marital violence are responding to continuous traumatizing events and thus their posttraumatic stress symptoms are likely to be recurrent and ongoing. Terr (1991) distinguished between two general types of childhood trauma experiences. Type I traumas result from a single event, such as an earthquake or a car accident. Type II traumas involves long-standing or repeated exposure to traumatic external events. Therefore, exposure to marital violence would be considered a Type II trauma in the majority of cases. Terr (1991) identified a number of symptoms specifically associated with Type II disorders: massive denial, repression, dissociation, self-anesthesis, self-hypnosis, identification with the aggressor, and aggression turned against the self.

Despite the obvious possibility that children living with marital violence may be at risk for developing PTSD, few studies have examined the prevalence of this disorder, or its associated symptoms, with this population. Lehmann (1997) examined the prevalence of Posttraumatic Stress Disorder in 84 children of battered women, aged 9 to 15 years, who were either residing in a women's shelter or undergoing treatment through the shelter. Children were assessed with the Children's Impact of Traumatic Events Scale - Family Violence Form (CITES-FVF), a child self-report measure that is administered in a structured interview format. The CITES-FVF was used to examine children's reactions to assault-specific events and determine if they meet the DSM III-R

criteria for a PTSD diagnosis. As well, the CITES-FVF measured attributions of danger in the world, personal feelings of vulnerability, and perceptions of self-blame and guilt. Over half of the children (56%) in this sample were found to meet the criteria for PTSD and no gender differences were found. Younger children in this study were found to be more likely to exhibit PTSD. In this sample, the PTSD group differed from the non-PTSD group on child self-report measures of anger, dissociation, depression, and assault anxiety.

Lehmann (1997) did not determine the co-occurence of emotional, physical, and/or sexual abuse, which may have been a factor in differences uncovered between the children meeting the PTSD criteria and those that did not. Therefore, this study only isolated one variable, and did not consider the effect of multiple types of negative experiences. However, this study did examine specific factors of children's exposure to marital violence. "Controlling for age, PTSD symptoms were related to the nature of the children's assaultive experiences (frequency of witnessing, duration, multiple abusive male models, and multiple separations) and intensified by the negative attributions of self-blame/guilt, dangerous world, and personal vulnerability" (Lehmann, 1997, p. 251). These finding suggest that external variables and internal processes may mediate the impact of marital violence on children.

Kilpatrick and Williams (1998) investigated the role of potential mediators in the development and severity of Posttraumatic Stress Disorder. The researchers studied 20 children identified as having been exposed to violence between their parents within the month prior, but who had not themselves been direct victims of violence and a matched

control group of 15 children. All children participating in this study were screened for other PTSD inducing experiences. The mediating variables examined in this study have been identified in both the PTSD and the domestic violence literature. The variables included: age, gender, locus of control, self-blame, perception of threat, active versus palliative coping style, maternal emotional health, and aspects of the marital violence. The specific aspects of the marital violence that were explored were the intensity, frequency, age the child was first exposed, and time that had elapsed since the last violent episode.

According to the childrens' self-rating on the Posttraumatic Stress Reaction Index (PTSRI), all but one of the children exposed to marital violence (n=19), in the Kilpatrick and Williams (1998) study were found to meet the criteria for a PTSD diagnosis (2 mild, 8 moderate, and 9 severe). None of the control group met the criteria for this diagnosis. Surprisingly, *none* of the identified variables were found to significantly contribute to the prediction of the level of PTSD. Therefore, the only factor, which predicted the development of PTSD in this study, was group status; whether or not the child had been exposed to marital violence. The results of this study speak to the powerful impact exposure to marital violence has on children's stress levels. Although this was a small sample of children, the fact that no variables, not even aspects of the marital violence, were found to be significant suggests that the severity and frequency of violence between parents did not affect its deleterious impact on the child. This finding highlights the catastrophic potential of exposure to marital violence (Kilpatrick & Williams, 1998).

Graham-Bermann and Levendosky (1998a) investigated traumatic stress symptoms in 64 children of battered women. The assessment of traumatic stress symptoms in children was made based on a parental report measure. Parents were presented with 17 questions that reflected the DSM-IV diagnostic criteria for PTSD that were adapted for use with the children in this study. Parents were asked to identify whether their child had experienced any of the symptoms as a direct response to the violence that the child had witnessed between the mother and her partner. Parents and teachers were asked to complete the CBCL and the children completed a measure of self-perception.

The parent-rating questions regarding PTSD symptoms were divided into three groups according to the diagnostic criteria: intrusive re-experiencing, avoidance of stimuli, and traumatic arousal symptoms. In this sample, 52% of the children met the requirements for intrusive re-experiencing, 19% had three or more persistent avoidance symptoms, and 42% experienced increased traumatic arousal symptoms. According to the parental ratings, 8 of the children (13%) met the DSM-IV criteria for a PTSD diagnosis. No gender differences were found in regards to posttraumatic stress symptoms in children in this sample.

No significant differences were found in regards to the frequency of PTSD symptoms between children who had been identified as having been physically abused themselves and those who had not. Graham-Bermann and Levendosky (1998a) reported that in their sample of 64 children exposed to marital violence, 70% were eyewitnesses, while the rest of this sample were reported by the parents to have overheard the violence

when it happened. There were no significant differences uncovered between those children who directly witnessed the abuse of their mother and those who did not with respect to the mean number of posttraumatic symptoms reported.

The study by Graham-Bermann and Levendosky (1998a) showed lower overall rates of PTSD than other investigations (Kilpatrick and Williams, 1998; Lehmann, 1997). However, it must be noted that each of these studies utilized different sampling methods, source of information, and diagnostic criteria. The sample utilized by Graham-Bermann and Levendosky (1998a) was particularly unique in that it utilized a sample of women and children residing in the community, not a shelter for battered women. It is important to note that as a group, the mothers studied in shelters may have endured more serious physical violence than battered women found in the community (Graham-Bermann and Levendosky, 1998a).

Graham-Bermann and Levendosky (1998a) suggested that reporting biases may be in part responsible for the lower rate of PTSD reported in that study as they utilized parent reports of children's PTSD symptoms. Other researchers have posited that mothers may tend to favor reporting externalizing symptoms while the children themselves are more likely to report internalizing symptoms (Sternberg, Lamb, Greenbaum, Cicchetti, Dawud, Cortes, Krispin, and Lorey 1993). "Thus, these assessments of PTSD are most likely underreported because they rely more on the characterization of internal states and less on the child's outward problematic behaviour" (Graham-Bermann & Levendosky, 1998a, p. 124). Parents in this study may not have noticed some symptoms, or may not have associated them with the marital violence that

the children had been exposed to (Graham-Bermann & Levendosky, 1998a). However, it should be noted that in this study there was a significant correlation between the mothers' and teachers' reports of the child's behavioural symptoms.

Graham-Bermann and Levendosky (1998a) also investigated the association between PTSD symptoms and other measures of child adjustment in this sample. Children with symptoms of intrusion, arousal, or a full PTSD diagnosis were found to have significantly higher scores on both the Internalizing and Externalizing behaviour problem scales of the Child Behaviour Checklist. Children's self-perception ratings did not significantly vary as a function of their posttraumatic stress symptoms.

> These results indicate that children traumatized by domestic violence are agitated and aggressive, in addition to being withdrawn and depressed – symptoms commonly associated with experiencing trauma. For example, the intrusive reexperiencing of memories may serve to upset the child, which in turn may arouse the child's fight or flight system of defense and may lead to aggression either against the self or against others. These findings suggest that trauma sequelae surely must be present in the children's interpersonal world and cognitive development as well (Graham-Bermann & Levendosky, 1998a, p. 122).

Despite differences in sampling and reporting methods, studies to-date have consistently identified a significant prevalence of posttraumatic stress symptoms in this population (13 % to 95 %). This finding furthers the application of a PTSD framework in attempting to understand children's responses to living with marital violence. Graham-Bermann and Levendosky (1998a) noted the need of a clinical tool for specifically

assessing this type of trauma in children. Nader (1997) reviewed the instruments available for generally assessing posttraumatic stress symptoms in children (such as the PTSRI used by Kilpatrick & Williams, 1998), but also highlighted a need for specialized instruments for specific forms of trauma. Some instruments have been adapted for this purpose, such the CITES-FV utilized by Lehmann (1997) and newer measures are also being developed, such as the Angie/Andy Cartoon Trauma Scales (ACTS) (Praver, Pelcovitz, & DiGiuseppe, 1998). The ACTS is a self-report measure that has been developed to assess posttraumatic stress and associated symptoms in young children who have experienced interpersonal trauma. This instrument is particularly unique, as symptoms are described in terms of another child's experience and the children do not need to verbalize their responses.

The overlap of trauma and behavioural symptomatology in studies of children in homes with spousal abuse leaves questions about whether these children are best thought of as traumatized, behaviourally disordered, or both.

> In treating child observers there are difficult diagnostic decisions to make: is a particular child traumatized and in need of safety and working through of trauma material, or is she/he depressed, conduct or attention deficit disordered and in need of treatment more specific to those disorders, or some combination? (Rossman, 1994, p. 30)

Rossman (1994) offered several considerations for professionals faced with such decisions. First, the child could be treated as a trauma victim and further diagnostic decisions could be delayed. If a formal diagnosis is required, family history or other

types of information regarding the child's pre-trauma functioning should be taken into account. Finally, both types of diagnosis may be deemed relevant and intervention efforts could address both of the child's treatment needs.

Cognitive and Attitudinal Factors

Children's cognitions and attitudes about violence and intimate relationships provide further information about how they may be at long-term risk. Children living with interparental violence may exhibit some specific concerns. Jaffe et al. (1990) classified these symptoms in three domains: responses and attitudes about conflict resolution; assigning responsibility for violence; and knowledge and skills in dealing with violent incidents.

> Sometimes these problem areas are not immediately apparent unless specific information is requested from children or they are observed in specific situations. These problem areas can be called the 'subtle symptoms' of witnessing wife assault, because they often require careful investigation to detect. Additionally, these subtle symptoms may be present in children who do not demonstrate any of the more dramatic emotional and behavioural adjustment problems (Jaffe et al., 1990, p. 51).

Graham-Bermann (1998) emphasized the role of the child in shaping the events around them. "Thus, his or her responses to the violence may, in part, be a function of temperament, intelligence, or some other 'intraindividual' quality that may serve to mediate the child's responses to the violence and hence presage the child's adjustment in the short and long term" (Graham-Bermann, 1998, p. 25). Therefore, child factors, such

as their understandings about violence and beliefs about relationships with other people need to be understood.

Several studies with children from maritally violent homes have investigated cognitive and attitudinal factors. Jaffe et al. (1988) examined 28 children, with a mean age of 9 years old, who were former residents of a shelter for battered women in relation to a control group of 28 children matched for age, sex, number of children in the family, and income level. The sample of children exposed to marital violence were found to be significantly more likely to condone violence as a means for resolving conflict. As well, the children of battered women were found to have less information on how to deal with emergency situations in the home. However, no significant differences were found between the two groups of children in terms of their view of their own responsibility for violence in their family.

Jaffe et al. (1990) listed numerous difficulties which may be associated with exposure to marital violence, including decreased confidence in their own future, feelings of guilt about the on-going violence, and an exaggerated sense of responsibility for the on-going marital violence. Lehmann (1997) observed that the negative attributions of children exposed to marital violence are most likely a function of how they process their experiences. "Blaming oneself and feeling guilty for the violence may result from not being able to stop the assaults, self-attributed negative behaviour, or parental statements" (Lehmann, 1997, p. 252). Over time, these negative attributions may become more global, and result in beliefs about personal vulnerability and perceptions of the world as a

dangerous place. These attributions may lead to the development of adjustment problems, such as social relationship difficulties (Lehmann, 1997).

Graham-Bermann and Brescoll (2000) investigated the stereotyped beliefs of 121 children aged 6 to 12 years old in families with varying levels of domestic violence. Findings suggested that children's cognitive belief systems may be affected by their exposure to marital violence.

> As predicted, the amount of physical violence and emotional abuse reported to be experienced by the mother was significantly related to how much children believed in the inherent superiority and privilege of men in the family and also to how much children believed that violence was an acceptable and even necessary part of family interactions (Graham-Bermann & Brescoll, 2000, p. 609).

However, an interesting finding in the Graham-Bermann and Brescoll (2000) study was that there was no direct link discovered between children's patriarchal views and parent ratings of the child's current level of psychopathology. The authors noted that the link between patriarchy and psychopathology may become more evident later in the child's development, particularly in boys who grow up to batter their partners (Graham-Bermann & Brescoll, 2000).

Although studies have found some variation, existing knowledge of the belief systems and attitudes of this population of children raises concern. Efforts to assess and modify these detrimental beliefs, even if the child is not currently displaying any emotional or behavioural concerns, may be of long-term benefit to the child.

Mediating Variables

Numerous variables have been repeatedly identified in literature reviews as potentially mediating or moderating the effects of marital violence on children, such as age, ethnicity, and child personality characteristics (Barnett et al., 1997; Holden, 1998; Kolbo et al., 1996). Three of the most commonly mentioned variables will be briefly discussed: gender, co-occurring physical abuse towards the child, and maternal stress.

Gender

The majority of the literature has reported conflicting results about trends of vulnerability between boys and girls of maritally violent homes. In addition, some studies have not found any gender differences in regards to children's well-being (Hughes, Parkinson, & Vargo; 1989; O'Keefe, 1994b). The lack of gender differences appears to be particularly consistent in regards to posttraumatic stress symptoms (Graham-Bermann and Levendosky, 1998a; Kilpatrick & Williams, 1998; Lehmann, 1997). There is also some suggestion that gender differences depend on the source of information (child, mother, or father) (Randolph & Conkle, 1993; Spaccarelli et al., 1994; Sternberg et al., 1993). "Collectively, the extreme non-comparability of these findings across divergent data sources, samples, measurements, and type of comparison data obtained leaves the issue of gender effects unsettled" (Barnett et al., 1997, p. 142).

Jaffe et al. (1990) suggested that by school age, gender-related differences have begun to emerge in outcomes for children exposed to marital violence. Boys are identified as aggressive towards others and towards objects, while girls tend to withdraw and report somatic complaints (Jaffe et al., 1990). McDonald and Jouriles (1991)

reported that trends in the empirical literature indicated both boys and girls have elevated scores on internalizing concerns and social competence problems, but for externalizing concerns only boys have elevated scores.

Kilpatrick and Williams (1998) suggested that these results might not be a reflection of true differences between girls and boys, but a reflection of differential modes of expression of the disturbance. Although studies of pre-adolescent school-aged children generally find that boys display the most problems, there is a possibility that gender differences may shift over time, with girls displaying greater concerns at later stages, such as adolescence (Jaffe et al., 1990). The lack of longitudinal studies with multiple sources of information (i.e. children, mothers, and other reporters) prevents a more clear understanding of gender differences in this population of children.

Concurrent Child Physical Abuse

Children who are exposed to marital violence have been shown to be at an increased risk to be victimized by other forms of abuse. Margolin (1998) estimated that approximately 45% to 70 % of children exposed to marital violence are physically abused. Appel and Holden (1998) reviewed 31 studies and found a median co-occurrence rate of spouse and child physical abuse of 40% in clinical samples. Some researchers suggest that marital violence may be associated with child behaviour problems simply due to its co-occurrence with physical abuse towards children (Jouriles and Norwood, 1995; O'Keefe, 1994a). The high likelihood of multiple abuse experiences co-occurring complicates the understanding of patterns of effect unique to

marital violence exposure. However, several studies have attempted to disentangle the contributions of each of these experiences in child outcomes.

Jaffe et al. (1986a) compared levels of adjustment problems in a group of boys identified as being physically abused (n=18), a group of boys from maritally violent homes (n=32), and a comparison group of children from nonviolent homes (n=15). No significant differences were found between the three groups in regards to social competence, however, group differences were uncovered in terms of behaviour problems. Physically abused boys and those boys exposed to marital violence had significantly higher scores of Internalizing and Externalizing behaviour problems in relation to the comparison group. In addition, the group of boys who were physically abused had significantly higher ratings of Externalizing problems as compared to the boys exposed to marital violence. However, these researchers note a caution with this study. The estimated overlap between marital violence and child physical abuse was as high as 40%, indicating that several of the boys in the abuse group may have been exposed to marital violence as well and several boys in the exposed group may have been physically abused (Jaffe et al., 1986a).

Davis and Carlson (1987) interviewed 78 mothers and their children at five domestic violence shelters. Parent-ratings were obtained on the Child Behaviour Checklist and compared to normative data on this instrument. Children in the sample were divided into those who had been exposed to marital violence (n=29) and those who were considered direct victims of parental abuse in addition to their exposure to marital violence in the home (n=32). In their sample of school-aged children (aged 6-11), 53%

of the physically abused group and 14% of the non-abused group fell within the clinical range on the Social Competence Scale of the CBCL. In regards to school-aged children, there was no significant difference between the two groups according to whether their behaviour problems fell within the clinical range (65% of those physically abused and 79% of the non-abused).

Another finding of the Davis and Carlson (1987) study was that children exposed to marital violence and physical abuse were likely to have higher scores on the aggression subscale compared to children who were not reported to have been physically abused. Those children also had significantly lower social competence scores and significantly more problems on the internalizing dimension compared to the children who were not reported to have endured physical abuse. Davis and Carlson (1987) summarized the findings of their study as well as that of Jaffe et al. (1986a) and concluded:

> Witnessing violence and being its victim both are related to the extent of behaviour problems exhibited by children, with some evidence that the combination of being a witness and being a victim has more serious consequences for the child (p. 283).

This finding was furthered by Hughes (1988), who compared children exposed to marital violence who were residing in a shelter (n= 95) with a comparison group (n= 83) on variables of self-esteem, anxiety, depression, and behaviour problems through the use of self-reports and mother's reports. This study further separated the children in the shelter into two groups: those who had been physically abused themselves (n=55) and those who had not (n=40). Both parent and self-report measures indicated significant

differences in rates of Internalizing and Externalizing behaviors between each of the three groups. The clearest differences were found between the comparison group and those children who had been physically abused in addition to being exposed to marital violence. However, significant differences were found between the comparison group and the shelter children who had not been physically abused in terms of the child-reported anxiety and self-esteem measures.

Hughes et al. (1989) investigated measures of depression, anxiety, and behaviour problems with physically abused (n=40) and non-physically abused (n=44) children living in a shelter for battered women. A comparison group consisted of 66 children from non-violent homes with similar economic backgrounds. Children were divided into three age groups (4 to 5, 6 to 8, and 9 to 12 years old) to take into account possible developmental differences in reactions to violence. No significant differences were found between the three groups in terms of the child self-report depression measure. Children's reports of their anxiety found that both of the groups (abused and non-abused) had significantly higher levels than the comparison group. Overall, children who had been physically abused as well as exposed to marital violence, were facing a "double whammy" and were functioning significantly more poorly than the comparison group (Hughes et al., 1989, p. 206). Children exposed to marital violence who were not identified as being physically abused fell between the other two groups in terms of behaviour problems.

These findings were only partially supported by Sternberg et al. (1993) who investigated child self-reports as well as parent-reports of behaviour problems in a sample

of 110 Israeli children. Children in this study were assigned to one of four groups: children who had been physically abused by their parents (n=33), children who were exposed to physical violence between their parents (n=16), children who had been both physically abused and exposed to marital violence (n=30), and finally a comparison group of children who had not experienced any form of family violence (n=31). This study was unique, as the children in the four groups did not differ in regard to socioeconomic status, apartment size, unemployment, stressful life events, birth order, birth complications, and health problems. As well, several confounding effects usually found in studies of this nature were eliminated, as children in this study were all living at home with both of their biological parents.

Sternberg et al. (1993) found that children in all three of the family violence groups had significantly higher depression scores on the CDI than the control group, however there were no significant differences found between the three groups. The children who were physically abused and the children who were both abused and exposed to marital violence were found to have significantly more Internalizing and Externalizing behaviour problems than the comparison group. The group of children who were exposed to marital violence did not have significantly higher scores than the comparison group. Overall, being exposed to marital violence did not seem to affect children's evaluations of their own adjustment as did being a victim of physical violence, or, a combination of both. Therefore, Sternberg et al. (1993) did not find support for the concept of physically abused children exposed to marital violence experiencing a "double whammy" as suggested by Hughes et al. (1989), as there were no consistent differences

between the physically abused children who were exposed to marital violence and the physically abused children who were not exposed to marital violence.

Some studies have discovered mediating factors that might help to explain the equivocal findings with regards to child physical abuse and exposure to spousal abuse. In a study of 185 children residing in a shelter for battered women, O'Keefe (1994a, 1994b) discovered that although violence between the child and the mother was a significant factor, the amount of father-child violence was *not* a significant predictor of child behaviour problems in that sample. O'Keefe (1994a, 1994b) suggested several ways of understanding this finding. First, this discovery may reflect the fact that these children rely less on their father for emotional support, therefore, physical abuse from their father has less of an impact on them. Another way of understanding this finding is that children may become numb to violence perpetrated by the father, due to repeated witnessing of father-to-mother violence. A third hypothesis suggested by O'Keefe (1994b) is that mothers who report high levels of mother-child violence may exaggerate reports of their child's behaviour problems in an attempt to justify their own behaviour.

Jouriles and Norwood (1995) investigated physical aggression towards children in 48 families (96 children aged 4- to 14-years old) residing in a shelter for battered women. Families in this sample were divided into two groups, "more extreme" and "less extreme" battering on the basis of mother's reports. Boys in this study were found to have higher levels of Externalizing problems than girls, however, this finding was only true for the families with "more extreme" battering.

Jouriles and Norwood (1995) concluded that the battering of women is associated with an increase in parental aggression towards sons in the home, but not daughters. In their study, families identified as having more extreme battering of the woman, both parents were found to be more aggressive towards sons than daughters. Mother's aggression towards her children was found to be associated with the child's Externalizing behaviour problems, which in homes characterized by extreme wife battering is most likely to be sons. Father's increased aggressiveness towards sons was not related to this increased Externalizing behaviour problems in this study. These results are similar to those reported by O'Keefe (1994a, 1994b). The variability of outcomes, even within samples of abused children exposed to marital violence, confirms that a wide variety of factors are contributing to children's well-being.

Parental Stress

Parental stress has been repeatedly identified as a mediating variable for children's outcomes in homes characterized by marital violence (Barnett et al., 1997; Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998). Levendosky and Graham-Bermann (1998) cited numerous studies indicating increased levels of depression, psychological distress, and posttraumatic stress symptoms in battered women compared to non-battered women and suggested that these factors may impact their ability to parent, which in turn affects their child's adjustment. This increased level of stress in battered women warrants concern for children's well-being. "Studies consistently indicate that maternal stress from violence or other sources has significant detrimental effects on children" (Barnett et al., 1997, p. 143).

Jaffe, Wolfe, Wilson, and Zak (1986c) compared battered women residing in a shelter to women from nonviolent families within the community who were matched for family income, length of marriage, and number of children. Battered women reported significantly higher levels of somatic complaints, anxiety, and depression and these concerns were found to be significantly related to stressors, such as the degree of negative life events experienced in the previous year.

Holden and Ritchie (1991) investigated relations between marital violence, parental behaviour, and child behaviour in a sample of 37 battered mothers living in a shelter and a comparison group of 37 mothers. The children in each of these two groups ranged between 2- to 8-years old. The amount of stress reported by the battered women in this study was the most powerful predictor of child behaviour problems. The relationship between maternal reports of parenting stress and child behaviour problems also held true for the comparison sample. Similarly, Levendosky and Graham-Bermann (1998) discovered that children whose mothers were reporting high levels of parenting stress exhibited more Internalizing, Externalizing, and total behaviour problems. "These results suggest that the children of women who feel less stressed by their parenting responsibilities in the face of domestic violence suffer less emotional and behavioural impact" (Levendosky & Graham-Bermann, 1998, p. 393). However, a study by Kilpatrick and Williams (1998) found that maternal stress did *not* contribute to the prediction of PTSD level in a sample of children exposed to marital violence.

Kilpatrick and Williams (1998) suggested that their finding might be due to differences in methods used for gathering information about child functioning. Unlike

this study, most investigations have relied solely on instruments that were completed by mothers in an attempt to gather child information. "It seems possible that maternal reports of children's behavioural and emotional problems may more truly be a reflection of the emotional well-being and coping level of mothers than an accurate indication of the children's level of difficulty" (Kilpatrick & Williams, 1998, p. 327). Therefore, studies utilizing childrens' self-reports of their own functioning may be most informative as they eliminate the possibility that mothers' ratings of their child's behaviour are heavily influenced by their own distress.

Pathways of Influence

Identifying mediating factors in outcomes for children living with spousal abuse does not necessarily explain the underlying mechanisms responsible. Cummings (1998) highlighted the need to explore the multiple forms of distress that are associated with marital conflict in order to have a more complete understanding of familial causal factors and subsequently increase our ability to predict child outcomes. "Although experts agree that marital violence has a deleterious impact on children's adjustment, little is known about the variables that may influence this effect" (O'Keefe, 1994b, p. 403).

Barnett et al. (1997) identified four main theories presented in the literature to account for negative outcomes in children who are exposed to family violence: social learning theory, Posttaumatic Stress Disorder (PTSD) theory, family disruption (stress) hypothesis, and attachment theory (emotional insecurity hypothesis). Hughes and Fantuzzo (1994) conceptualized the mechanisms of affect in terms of *direct* and *indirect* sources of influence. The aforementioned theories will be discussed in terms of these

two general categories. Finally, a developmental psychopathology approach to understanding outcomes for children exposed to interparental violence is discussed.

Direct Influences

In social learning theory children are thought to learn directly, from observation of their parents, to be violent (Barnett et al., 1997). These lessons of modeling are then further supported through the lack of punishment of aggressive acts, adoption of parental beliefs regarding the acceptability of violence, and a lack of modeling of problem-solving and conflict resolution skills. "Observation leads to imitation of behavioural aggression and cognitive incorporation of proviolence attitudes" (Barnett et al., 1997, p. 147).

Social learning theory suggests that behaviour patterns are overlearned in early childhood interactions with others and are automatically used by the child when they are adapting to new circumstances (Graham-Bermann, 1998). Hughes and Fantuzzo (1994) noted that there is a "disinhibitory" impact associated with watching a parent display aggression that gives a child permission to be aggressive as well. Jaffe et al. (1990) noted that to latency-aged children their parents are significant role models, thus these children quickly learn the use of violence to resolve conflict. As well, girls may learn that their own victimization is inevitable (Jaffe et al., 1990). Children may adopt not only the violent tactics, but a complex grouping of behaviours including manipulation, cajoling, and coercion (Graham-Bermann, 1998).

Support for the social learning theory explanations of adjustment with regards to children exposed to marital violence is found in retrospective investigations, pointing to an intergenerational transmission of family violence. Randolph and Conkle (1993)

reviewed the literature on retrospective studies of marital violence and concluded that children from homes characterized by spousal abuse are "significantly more likely to engage in interpersonal aggression, and to remain in an abusive relationship" (p.23). This finding is supported by the 1993 Violence Against Women Survey (VAWS) found that "men who witnessed violence by their fathers were three times more likely than men without these childhood experiences to be violent toward their wives" (Statistics Canada, 2000, p. 16). Sugarman and Hotaling (1989) uncovered two factors that significantly differentiated severely violent men from groups of men deemed as nonviolent, verbally aggressive, and those exhibiting minor physical violence: socioeconomic status and frequency of *witnessing* violence in their family of origin. Interestingly, that study did not find *experiencing* violence in the family of origin to discriminate the severely violent men from the other three groups. Carlson (1990) found some indications that adolescent boys who had been exposed to marital violence were more likely than their peers who had not lived with marital violence to run away from home, have self-injurious thoughts, and be more directly violent towards their mothers.

The Posttaumatic Stress Disorder (PTSD) theory assumes that children are adversely affected by violence-related stress reactions. Therefore, behavioural outcomes identified in children exposed to marital violence may simply be PTSD symptoms (Barnett et al., 1997). Hughes and Fantuzzo (1994) concur that exposure to violence between one's parents is a major stressor that can produce various difficulties, including symptoms of Posttraumatic Stress Disorder. Graham-Bermann (1998) noted that the child's perception of danger, degree of perceived protection, the meaning of the event,

and the immediate response of caretakers influence the degree of trauma that a child may experience. Trauma symptoms may interfere in a variety of environments, such as in performance at school, and may persist over time. For example, childhood exposure to interparental abuse was found to be related to depression, trauma-related symptoms, and low self-esteem in female college students and the same association was found for trauma-related symptoms for men (Silvern, Karyl, Waelde, Hodges, Starek, Heidt, & Min, 1995).

Indirect Influences

Levendosky & Graham-Bermann (1998) separated women's abuse histories into psychological and physical abuse. While both types of abuse significantly impacted parental stress, psychological abuse was found to be the stronger predictor of children's adjustment. This distinction supports theories that emphasize the role of non-direct effects of violence in homes characterized by spousal abuse. There are negative factors impacting a child even when an incident of physical abuse is not occurring in the home. This "toxic environment" is comprised of on-going fear, anxiety, anger, and tension resulting from verbal abuse and insults which, among other consequences, is likely to leave the mother disempowered (Health Canada, 1999).

> Although much of the research on domestic violence focuses on the violence per se as the independent variable affecting the child, it is likely that this violence is actually an expression of underlying family dysfunction even more profound than the acts of violence themselves. (McCloskey, Figueredo, and Koss, 1995, p. 1241)

In the family disruption hypothesis children's symptoms are thought to originate indirectly from the negative events related to marital violence. In addition to dealing with stressful, unpredictable violence, children are also affected by factors that may be considered secondary effects of the violent situation. Factors such as frequent moves, economic hardship, alcohol problems, and parental separation are thought to tax both the child's and the parents' coping abilities (Barnett et al., 1997; Spaccarelli et al., 1994). "The disruption hypothesis, therefore, accounts for the adjustment problems of children of battered women on the basis of their attempts to cope with extremely unpredictable and far-reaching changes in the family unit" (Jaffe et al., 1990, p. 62). Laumakis, Margolin, and John (1998) suggested that some messages children receive, such as parental threats to leave the home, may be even more disturbing to them than marital violence.

Holden and Ritchie (1991) reviewed the literature pertaining to parenting behaviours in homes characterized by marital discord and highlight three main areas of concern. First, problems between mothers and their spouses may result in heightened maternal stress that may decrease the level of the mothers' emotional availability to their children. Osofsky (1998) discussed the need to support parents, particularly mothers, in regards to their own trauma so that they are then more available to deal with their children's fears and problems. "For traumatized parents, unfortunately, their children's distress frequently acts as a reminder for the parents of what they wish to forget and, therefore, may reawaken fears contributing to their difficulty in attending to their children's distress" (Osofsky, 1998, p. 106).

Secondly, Holden and Ritchie (1991) suggested negative marital interactions might be associated with more negative child-rearing practices and more negative parent-child interactions. Through observations of parenting interactions with their children, Holden and Ritchie (1991) discovered differences between battered women and comparison mothers. For example, battered women were found to attend less to their children and experience more conflicts with their children in relation to the comparison mothers. "These results indicate that there are indeed effects on the quality of the mother-child relationship associated with being in a violent marital relationship" (Holden & Ritchie, 1991, p. 324). Negative parenting may also be a factor for the abuser. Battered women in the Holden and Ritchie (1991) study consistently reported that their husbands were much more irascible, less involved in child rearing, and more likely to use negative control techniques. Maternal reports indicated that paternal irritability was also a significant predictor of child behaviour problems.

Finally, Holden and Ritchie (1991) noted the association between marital discord and an increase in inconsistent discipline practices by parents. In their study Holden and Ritchie (1991) found that inconsistency in parenting was the only self-reported difference between the two groups. Two types of parental inconsistency were identified in this study: between-parent and within-mother. Within-mother inconsistency variables were thought to be purposeful attempts by the battered women to avoid creating anger in their abusive partner. Barnett et al. (1997) noted that the lack of fulfillment of parental roles is a serious culprit in the negative effects observed in children exposed to marital violence. "In fact, their inadequate coping might be more detrimental to children than the actual

observation of violence" (p. 139). Levendosky & Graham-Bermann (1998) posited that increased parenting stress may cause mothers to react to their children's behaviours less effectively, leading to the development of more internalizing and externalizing behaviour problems.

Attachment theory provides an emotional insecurity hypothesis to explain the outcomes of children exposed to marital violence. Marital conflict and violence interfere with parent-child bonding and have the potential of making children feel insecure (Barnett et al., 1997). The experience of marital violence is related to the development of problematic relationship schemas that influence children's expectations and motivate their behaviour. "One of the important tasks of early childhood is the development of secure family relationships, which affect all future social relationships" (Graham-Bermann, 1998, p. 40).

Interadult anger is thought to contribute to children's emotional insecurity. For example, E.M. Cummings, Vogel, J.S. Cummings, and El-Sheikh (1989) examined children's responses to various forms of expressions of anger between adults. Children aged 4 to 9 years old were shown videotaped segments demonstrating non-verbal, verbal, and verbal-physical anger and then asked questions about their responses. Children viewed all angry interactions, including non-verbal anger, as negative events and reported that they elicited negative emotions. Verbal-physical anger was perceived by children to be the most negative expression of anger. A gender difference was noted, as boys in the study reported more angry feelings in response to the angry interactions than did the girls.

Children in this study who were from homes characterized by marital violence and children with behaviour problems reported greater distress.

A particularly interesting discovery in this study was that compared to resolved anger, unresolved anger was perceived to be much more negative and created greater distress in children. Cummings et al. (1989) conclude that "the resolution of disputes by adults in front of children may go a long way toward ameliorating the impact of conflict on children" (p. 1401). Further analogue studies have provided information about the benefits of conflict resolution. Cummings, Simpson, and Wilson (1993) studied the reaction of children aged 5- to 6-years old and 9- to 10-years old to videotaped scenarios of adult conflicts with various endings. The negative effects of adults' disputes on children were found to be reduced even when resolution between the adults occurred behind closed doors. As well, negative reactions in children were shown to be reduced by an adult's subsequent description of a resolution. The sensitivity in children as young as 5- and 6-years old to adult expressions of anger was further demonstrated, as they were shown to be capable of inferring resolution from incomplete information. Cummings et al. (1993) suggest that parental conflict resolution may ameliorate the negative impact of exposure to interspousal violence. Children's responses to resolution may not be as clear if violence is chronic, however, attempts to find some resolution is likely to be beneficial in all families (Cummings, 1998).

Cummings and Davies (1994) summarized the literature demonstrating a causal link between interadult anger (not necessarily violence) and children's anger and aggression. "The research supports the notion that exposure to marital discord can

instigate hostility in children, regardless of parenting practices or any other aspects of family functioning" (Cummings and Davies, 1994, p. 47). *However*, this literature also suggests that repeated exposure to marital conflict sensitizes children, which increases their arousal and aggression when exposed to anger (Cummings, 1998). Children from families with high levels of marital conflict, such as violence, are disproportionately more sensitized to unresolved conflicts than other children. "The process of sensitization is thus emerging as key suspect in the search for the processes that mediate children's risk for adjustment problems caused by their exposure to marital conflict and violence" (Cummings, 1998, p. 78). Therefore, an emotional security hypothesis provides a framework for making theoretical sense of the overall pattern of children's emotional, cognitive, and behavioural responses (Cummings & Davies, 1994).

Emotional insecurity resulting from marital abuse may be a vulnerability factor, decreasing a child's resilience in the face of further adversity (Cummings, 1997). Therefore, parental conflict resolution might serve two purposes. First, it may be both a compensatory factor which helps all children cope with marital conflict. Secondly, resolution may be a protective factor for children from homes with particularly intense conflict (Cummings, 1997).

It appears most likely that a combination of direct and indirect factors associated with marital violence account for the variety of concerns and multifonality identified with this population of children. "Besides inappropriate modeling of conflict resolution, these children are affected by their mothers' diminished effectiveness as a parent, negative

changes in family status, and related factors that result from family violence" (Wolfe, Jaffe, Wilson, & Zak, 1988, p. 239).

Research has provided support for both direct and indirect pathways of influence. Spaccarelli et al. (1994) found that marital violence itself accounted for only a limited amount of unique variance in child adjustment variables. However, these authors warn that this finding does not mean that spousal abuse has no impact on children, but that it is "an important part of a complex set of demographic and historical predictors of mental health problems for children" (Spaccarelli et al., 1994, p. 92). Support for the more direct effects of marital violence is found in previous studies which have discovered that children in maritally violent homes have poorer functioning than children living with non-violent marital discord (Hershorn & Rosenbaum, 1985; Jouriles, Murphy, & O'Leary, 1989).

Wolfe et al. (1985) discovered that a significant portion of children's adjustment problems were likely transmitted through the effects of marital abuse on their mothers. This finding is confirmed by a study by Levendosky, Lynch, & Graham-Bermann (2000) that found that the majority of women believed their partner's violence affected their parenting. As well, Levendosky & Graham-Bermann (2000) found that battering has a direct negative impact on women's parenting. Parents experiencing trauma have a decreased ability to play a stable, supportive role in their child's life (Osofsky, 1999). Another example of this is that conflictual, nonviolent marital interactions have been found to influence subsequent parent-son interactions (Jouriles & Farris, 1992). However, not all studies have corroborated these theories of diminished parenting

capabilities. Holden, Stein, Ritchie, Harris, and Jouriles (1998) found no evidence for battered women to be less affectionate, proactive, or less likely to provide structure to their child.

Developmental Psychopathology

Developmental psychopathology emphasizes dynamic processes of interaction between multiple intra- and extra-organismic factors (Cummings, 1998). Therefore, both direct and indirect influences of marital violence in the home environment interact with children's individual characteristics. "With its emphasis on the study of developing systems, this theory views normal development in terms of a series of interrelated social, emotional, cognitive, and social-cognitive competencies" (Wolfe and Jaffe, 1991, p. 287). According to this stress and coping approach, negative outcomes in children develop gradually as a result of interactions between the individual and their environment. "The development of psychopathology in family contexts reflects a series of microsocial processes that occur interactively over a period of time, reflecting gradual adaptations by children to family circumstances" (Cummings, 1998, p. 65).

> To understand the effects of family violence and abuse on children's development, therefore, we must place their experiences in a broader context that includes their perceived emotional climate of the family, their previous experiences with conflict and abuse, their interpretations of violence and maltreatment, and their available coping abilities and resources to countermand stress and inadequate caregiving. (Wolfe and Jaffe, 1991, p. 287)

The exposure experiences are then mediated by individual characteristics (such as age, gender, race, and ethnicity) and environmental characteristics (such as general life stress and inadequate maternal functioning) (Barnett et al., 1997). Therefore, individual experiences define the trauma a child has endured, while both individual and environmental characteristics mediate the resulting effects. "When coping is viewed from a contextual perspective, emphasis is placed on the specific contexts, as guided by personal appraisals of situations, especially perceived ability to cope (i.e., coping efficacy)" (Cummings, 1998, p. 64). In addition, the parameters of exposure unique to each child's experience of marital violence, i.e. frequency, severity of violence, recency, and multiplicity of types of exposure (Barnett et al., 1997). "The risk and resilience model inherent in developmental psychopathology approaches is important for contextualizing the violent events in the home and for describing the ways in which buffers and challengers can diminish or protect the child's social development" (Graham-Bermann, 1998, p. 24).

Group Treatment Interventions

Several researchers have identified the need to provide crisis intervention for children living in shelters for battered women (Alessi & Hearn, 1998; Lehmann & Carlson, 1998; Lehmann & Mathews, 1999). However, the population of children exposed to marital violence is much more expansive than the limited numbers living in shelters. Statistics Canada (2000) reported that transition homes were used by only 11% of female victims of violence.

> Most children of battered women do not reside in shelters at any given point in time, but are living at home. Some of them continue for years to witness violence or live with the threat of violence. Others live with the memories of witnessed violence and its after-effects such as emotional and physical scars, separation and divorce, and financial deterioration. The cessation of violence is not sufficient for healing from its effects and related difficulties (Peled, 1997, p. 288).

Group treatment programs for children living at shelters or in the community have been the most common form of intervention targeting this population. Group treatments are appealing to service providers as they are both time and cost effective. Terr (1995) noted that while group therapies are potentially helpful and are far less costly than the long-term individual treatments, children who have been seriously traumatized might need individual therapy in addition to group work.

Peled and Edleson (1995) reviewed the limited literature on group work with children of battered women and concluded that the majority of programs involve 6 to10 highly structured sessions with educational activities that target six general goals: (a) to define violence and the responsibility for violence; (b) to express feelings, such as anger; (c) to improve communication, problems-solving, and coping skills; (d) to increase self-esteem; (e) to develop social support networks; (f) to develop safety plans; and (g) to feel safety and trust during group sessions. Several authors have also emphasized the need to help children shed the belief that marital violence is a necessary "family secret", as this idea can be very isolating (Peled and Davis, 1995; Peled and Edleson, 1992; Wilson, Cameron, Jaffe, and Wolfe, 1989). These general goals coincide with the therapeutic

aims of group interventions for children with Posttrauamtic Stress Disorder; sharing of feelings and experiences, boosting children's sense of coping and mastery, and sharing problem-solving ideas (Yule & Canterbury, 1994).

Wagar and Rodway (1995) noted the importance of providing parents with concurrent treatment programs in order to increase the effectiveness of child interventions. Parenting groups provide an opportunity to support and encourage positive parenting practices, as well as discuss alternatives to physical punishment of children (Hughes & Marshall, 1995). Parental programs are likely to make the home environment more supportive to the child's new knowledge, as well as enhancing parental functioning (Davis & Carlson, 1987; Peled, 1997). Although these groups are generally aimed at serving abused women, Peled (2000) suggested that an additional parenting intervention for abusive men might be beneficial to the development of more positive father-child relationships.

Peled (1997) notes that there have been very few attempts to evaluate group treatment programs for children exposed to marital violence in the professional literature. When considering assessment outcomes for intervention programs it is important to remember that there are numerous factors that may influence children's needs in treatment and their subsequent response. "Individual differences in achieving goals are likely to arise from a multiplicity of factors such as the children's personalities and histories, the group leaders' personalities and training, and the group composition" (Peled and Edleson, 1995, p. 80).

Several methodological issues have resulted in limited information regarding the effectiveness of children's group treatment programs for exposure to marital violence (Barnett et al., 1997). Evaluation attempts have generally neglected to use standardized measures of adjustment (i.e. anxiety and depression), but have primarily relied on questionnaires addressing knowledge and attitudinal factors. As well, only a minority of evaluations of group treatment programs for children exposed to marital violence have utilized control groups. Another limiting factor with research in this field is the high attrition rate over the course of treatment programs (Peled & Edleson, 1998; Tutty & Wagar, 1994).

Jaffe, Wilson, and Wolfe (1986) examined the initial impact of a psychoeducational group program for children exposed to marital violence on 18 children aged 8- to 13-years old. Sixty-two percent of mothers stated that their children had learned something from their attendance in the program, however, only one-third of the mothers felt that the group had led to any significant behaviour change in their child. This result was not unexpected, as the researchers had anticipated that gradual behaviour change may result over time from the attitudinal change and skill development that was the focus of the program. However, no attempts to track longer-term changes were mentioned in this study. Changes were found in children's practical skill level, as they were able to identify more strategies for handling emergency situations, such as dialing 911. Positive shifts were also found in terms of child self-perception and attitudinal changes. An important finding in this study was that the group program was associated

with a decrease in the extent of violence that a child condoned between parents and towards children.

Jaffe et al. (1988) investigated the outcomes for 64 children, aged 7- to 13- years, referred to a group counselling program for children who had witnessed marital violence. Interviews conducted after the completion of the group indicated that the vast majority of mothers in this study (88%) believed that their child enjoyed the group and reported that they perceived an improvement in their child's behavioural adjustment. However, these reports were not corroborated by results on the Child Behaviour Checklist for the children who were administered this instrument at pre- and post-treatment times (n=18). Despite positive trends in the problem and social competence scales, there were no significant changes on the CBCL between children's pre- and post-intervention scores. Jaffe et al. (1988) noted that this finding was not surprising, as the group counselling intervention was not likely to immediately impact children's emotional and behavioural concerns and suggest that it is unrealistic to expect that a ten-week intervention program for children will eliminate behavioural acting out. This study did detect a shift in knowledge variables for the children between the two times. After the group intervention, children reported significantly more safety skill strategies and they reported more positive perceptions of their mother and fathers.

Gruszniski, Brink, and Edleson (1988) analyzed clinical rating scales completed by group leaders for 371 children accessing treatment over several years. These researchers concluded that the majority of children made positive gains in terms of problem-solving skills, self-protection resources, and self-esteem. As well, children were

reported to identify that the violence in their families was not their fault. A qualitative evaluation of a children's group treatment program conducted by Peled and Edleson (1992) gathered information from children, parents, and group facilitators. Children were reported to have shared their feelings in the group, revised their definitions of violence, identified that other children experienced marital violence, and had a better understanding of how to protect themselves. Children also perceived the group as a "safe, fun, and self-affirming environment" (Peled & Edleson, 1992, p. 340).

Marshall, Miller, Miller-Hewitt, Sudermann, and Watson (1995) examined pre- and post- intervention measures in 31 children, aged 7- to 15-years old who were attending a 10 week group counselling program. Results of survey question after the completion of the group indicated that the vast majority of mothers felt that the group intervention had been helpful for their child. Children were administered the "Pre-Post Child/Teen Questionnaire/Interview" (Marshall et al., 1995) which assessed their knowledge and attitudes about marital violence. Results indicated that after the group experience, children were better able to identify abuse and to use non-violent conflict resolution skills. As well, children reported that they were less likely to intervene in violent acts between their parents, less likely to condone the use of violence in relationships, and less likely to believe that they were the cause of fighting between their parents.

Wagar and Rodway (1995) conducted one of the few treatment evaluations with this population of children to utilize a control group. These researchers assessed outcomes for a treatment program (developed by Jaffe, Wilson, & Wolfe, 1986) that

involved direct instruction regarding attitudes and responses to anger, knowledge and support around the use of safety skills, and attributions for the responsibility for violence. Thirty-eight children ages 8- to 13- years old were randomly assigned to either the treatment or control group. Children in the treatment program were found to have significantly improved knowledge on two of three teaching objectives compared to the control group. The children in the treatment group were shown to have significantly higher post-tests on 1) attitudes and responses to anger and 2) sense of responsibility for parents and the violence. The variable that the treatment did not appear to have a significant impact on was children's knowledge of safety and support.

Program evaluations to-date indicate cause for optimism about the ability of group treatment interventions to facilitate some knowledge and attitudinal shifts in children, however, *none* of these studies have identified resulting affective and/or behavioural changes. Peled and Edleson (1995) note that short-term programs (i.e. 10 weeks) are an important starting point on the child's healing journey. However, time-limited group interventions are not a panacea for years of exposure to marital violence. Children's unique experiences of violence and family context variables translate into complex pathways to change and healing (Peled & Edleson, 1992).

Suggestions from the Literature

Several methodological issues have plagued research efforts with children of marital violence. "Research in the field is relatively new, exceptionally difficult to conduct, and limited so far" (Barnett et al., 1997, p. 156). The main concerns highlighted in the literature include: almost exclusive use of small shelter samples; insufficient use of

comparison groups; the use of non-standardized measures; failure to ascertain adequately exposure to violence; failure to evaluate multiple sources of stress; and reliance on maternal reports as the major source of data (Barnett et al., 1997; Holden, 1998; McDonald & Jouriles, 1991). "The complexity of conducting research about children exposed to marital violence has left investigators with considerable uncertainty about their generalizability" (Barnett et al., 1997, p. 145).

The most common source of participants for studies assessing the impact of marital violence has been children residing in shelters for battered women. These children are likely to be different from the general population of children exposed to marital violence in many ways, such as family income and social support. As well, children living in shelters are coping with numerous disruptions in their existing support systems, such as school and friends (Barnett et al., 1997; Jaffe, Hurley, & Wolfe, 1990; Lehmann & Mathews, 1999). Although shelter samples are convenient, in addition to validity issues of sampling, they also yield small numbers of children.

Finding comparison groups matched on numerous variables, such as socioeconomic status, and determining that no violence takes place in these homes can be a difficult task (Randolph & Conkle, 1993). As well, comparison groups for evaluations of treatment interventions for children exposed to marital violence pose several methodological and ethical limitations. Several studies have dealt with this issue by utilizing standardized measures of adjustment which have been used extensively with this population and have been demonstrated to have strong validity and reliability (Davis & Carlson, 1987; Hughes & Barad, 1983; O'Keefe, 1994b; Randolph & Conkle, 1993).

Therefore, norms provided for these instruments can serve as comparison data. However, the lack of comparison groups in studies of children in homes characterized by marital violence makes establishing cause-and-effect relationships much less clear. Holden (1998) emphasized the need for longitudinal studies assessing this population of children. Methodological progress is evident in the growing trend to utilize standardized measures to asses impact on children, however, this continues to be a concern with studies assessing the effectiveness of intervention attempts.

Graham-Bermann and Levendosky (1998b) note that research on marital violence demonstrates that "...the abuse of the mother by the partner may not only find expression in overt acts of violence, but that such acts are nested in a web of intimidating modes (i.e., threats, insults, psychological abuse, isolating tactics, etc.), on the part of the abuser" (p. 62). These authors conclude that the emotional abuse of the mother should be investigated in studies of the impact of marital violence on children, as exposure to marital violence assumes a certain amount of exposure to verbal/emotional abuse between partners as well (Graham-Bermann and Levendosky, 1998b). O'Keefe (1994b) notes that the type(s) of violence that children are exposed to be an important mediating variable that has not yet received enough systematic investigation in the literature. In particular, the physical abuse of the child is determined to be an important vulnerability factor that needs to be taken into account with this population.

Hughes (1988) highlights the need to separate out abused and non-abused samples of children exposed to marital violence in order to gain a clearer understanding of their psychological functioning and their responses to different external factors. The need to

carefully define samples is emphasized by suggestions from the literature that physically abused children exposed to parental violence are less well adjusted than those who have not been physically abused (Davis & Carlson, 1987; Hughes, 1988). In summary, studies to-date have inadequately assessed, and described, the types of violence and general family context that children are living in (Barnett et al., 1997; Holden, 1998).

Several researchers have noted the need to further investigate variables such as gender, ethnicity, and socioeconomic factors, as they have not yet been adequately explored (Graham-Bermann, 1996; Holden, 1998; McCloskey et al., 1995; O'Keefe, 1994a). A better understanding of these variables may illuminate our understanding of the pathways of effect and account for some of the variance across studies in this area.

Initial studies of children exposed to marital violence have relied almost exclusively on data taken from mothers (O'Keefe, 1994b; Jaffe et al., 1985). Numerous researchers have emphasized the need to obtain information about children's functioning from multiple sources (Graham-Bermann, 1996; Holden, 1998; Hughes, 1988; Kolbo et al., 1996; Sternberg et al., 1993). The importance of utilizing a variety of reporters, including the children themselves, appears to be particularly critical for the assessment of internalizing concerns (Spaccarelli et al., 1994; Sternberg et al., 1993). "Ideally, understanding anxiety symptoms in the child would include efforts to obtain the child's perceptions of the nature and sources of his or her anxiety, in conjunction with information about the child's well-being gathered from other sources" (Graham-Bermann, 1996, p. 281). Other potential sources of information are fathers, teachers, and research observers.

Despite recent strides in methodological structuring, a recent review of the literature by Edleson (1999) identified three concerns still predominant in empirical studies with children in families characterized by marital violence. These limitations are: a failure to identify physically abused children in the sample, a heavy reliance on shelter samples, and an almost exclusive reliance on mothers as a source of information.

Summary

The literature on children exposed to interparental violence strongly points to potential concern for their emotional and behavioural well-being in childhood, and even into adulthood. Growing empirical evidence has identified symptoms of anxiety, depression, and behavioural concerns, as well as posttraumatic stress symptoms in this population of children. In addition, this type of ongoing trauma may influence childrens' cognitions and attitudes about the appropriateness of violence as a problem-solving method. Some mediating variables, such as the child's sex, co-occurring child physical abuse, and parental stress have been identified as influencing the impact of exposure to marital violence on children. However, the exact pathways of effect remain unclear. There appears to be both direct and indirect influences affecting children, which results in diverse outcomes within this population. Group treatment programs for children are increasingly prevalent, however, little research with standardized measures of affective and behavioural health have been utilized. Research in this field has been hampered by methodological issues, such as sole reliance on mothers as sources of information about the child and little attention to other situational factors.

CHAPTER THREE: METHOD

Analysis Plan and Research Questions

The purpose of the present study was to describe affective, behavioural, and knowledge variables in a sample of children exposed to marital violence who were commencing a group treatment intervention. Parental stress measures were also taken from the child's parent who was attending a coinciding group program. Several factors were explored, including, source of report and potential mediating influences on children's outcomes. The variables were then re-assessed at the conclusion of the parents' and childrens' intervention programs, to assess for any significant shifts over the 10-week period.

The analysis plan and research questions are presented in two parts. The first section examines characteristics of this sample of children and parents at the initial intake for the group treatment program (Time 1). The second section addresses the changes expected on child and parent measures between Time 1 and the ninth week of the intervention (Time 2). In this study significant differences are considered to be those at the $p<.05$ level.

Characteristics of this Sample at Time 1

Comparisons with Normative Data

An objective of this study was to determine if this sample of children exposed to marital violence had elevated rates of clinical scores on measures of affect and behaviour compared to normative data. As well, parent reports of stress in this sample were compared with normative information. Frequencies and percentages of scores in the

clinical range were calculated and compared with rates of clinical scores in the normative data provided for the measures. Considering the previously reviewed literature and the fact that these children were being brought to an agency for treatment, the following results were expected:

1. Children in this sample would have markedly elevated rates of clinical scores than expected in normative samples on measures of depression, anxiety, competence, and behaviour problems.

2. Parental reports of stress in this sample would reveal significantly more scores in the clinical range compared to normative samples in child domain, parent domain, and life stress scores.

Correlation of the Angie/Andy Cartoon Trauma Scales with Related Measures

An aim of this study was to examine the Angie/Andy Cartoon Trauma Scales (ACTS) (Praver et al., 1998) in relation to other instruments, as it is a relatively new measure for assessing posttraumatic stress symptoms in children. A bivariate correlation was utilized to examine if this measure corresponded significantly with more established self-report measures of children's affect. It was expected that:

3. Scores of children's depression and anxiety would be significantly positively correlated with the child's ACTS score (posttraumatic stress symptoms).

Correlation between Parent Reports and Child Self-Reports

Another objective of this study was to assess the relatedness of child self-reports and parent reports of child functioning. Therefore, a bivariate correlation was conducted to compare these two types of reports in terms of childrens' internalizing concerns.

Despite some reported disagreement in past studies, parent and child reports were expected to be significantly correlated. Thus, it was expected that:

4. Child self-report measures of anxiety, depression, and posttraumatic stress symptoms would significantly correlate with the parents' rating of their children's internalizing behaviour problems.

Correlation Between Parental Stress and Child Functioning

A bivariate correlation was conducted to examine the relationship between parental stress and child measures of anxiety, depression, posttraumatic stress symptoms, competence, and behaviour problems. The current literature has suggested that parental stress is related to emotional and behavioural functioning in their children. It was expected that:

5. Parents' rating of total stress would be positively correlated with anxiety, depression, posttraumatic stress symptoms, and behaviour problems in children. Also, parent's total stress was expected to be negatively correlated to children's competence scores.

Between Group Differences within the Sample

Three different between group comparisons were examined for children's scores at the first assessment period. The first aim was to explore group differences between children who reported elevated rates of posttraumatic stress symptoms and those who did not, in regards to the other parent and child report measures. The second aim was to examine differences between children who were identified as being physically abused and those who were not in terms of the parent and child measures. Finally, gender

differences were explored in this sample. In order to investigate potential differences, a series of multivariate analyses were run for each of these three different groupings. Based upon the reviewed literature, the following results were expected:

6. Children who were at clinical levels on the ACTS would have significantly higher scores in measures of anxiety, depression, and behaviour problems than those with non-clinical ACTS scores. As well, they would have significantly lower ratings of social competence, significantly lower knowledge scores, and their parents would report significantly higher levels of stress.

7. Children who were reported to have been physically abused in addition to being exposed to marital violence would have significantly higher scores on measures of depression, anxiety, posttraumatic stress, and problem behaviours compared to children who were not reported to have endured physical abuse. As well, the physically abused children would have significantly lower competence scores, significantly lower knowledge scores, and their parents' self-reports would demonstrate significantly higher levels of stress.

8. Boys in this sample would score significantly higher in terms of externalizing behaviour problems and have significantly lower scores of competence compared to girls.

Changes in this Sample from Time 1 to Time 2

The final objective of this study was to determine if there had been any significant shifts in the child and parent measures from the initial intake (Time 1) to the assessment period at the ninth week of the intervention (Time 2). Significant differences were predicted on child and parent measures as intervention programs were provided for both

of these groups. In order to assess this, a paired t-test was conducted and the rates of clinical levels for the parent and child measures at both time periods were examined. The following results were expected:

9. Childrens' scores of depression, anxiety, posttraumatic stress, and behaviour problems would significantly decrease between Time 1 and Time 2 and less children would have scores in the clinical range at Time 2.

10. Childrens' knowledge scores would significantly increase between Time 1 and Time 2.

11 Parent self-reports of stress would significantly decrease at Time 2 and there would be fewer scores in the clinical range at Time 2.

Participants

This study, which had approval from the University of Calgary Ethics Committee, examined children enrolled in the group treatment intervention at the YWCA Sheriff King Family Violence Prevention Centre in Calgary for the Fall 2000 (September – December). Children were included in the study if they met the following criteria: a) they were between 6 and 12 years old; b) this was the first time they were participating in the group program; c) a parent completed a consent form (Appendix A) and the child's verbal consent was given. Forty-seven children aged 6- to 12- years old (see Table 1), with a mean age of 9.02 (SD=1.91) met the first two criteria, and consent was provided for all of these children to participate. However, for various reasons that will be discussed, incomplete data was collected for some children at one or both of the assessment times.

Table 1

Frequency and Distribution of Child Age

Child Age (years)	Number of Children	Percent of Sample
6	5	10.6
7	6	12.8
8	9	19.1
9	9	19.1
10	6	12.8
11	5	10.6
12	7	14.9
TOTAL	47	100.0

The children in this study were predominately Caucasian and there was a very even distribution of males and females in the group (Table 2). Most of the children had never lived at the YWCA Sheriff King Family Violence Prevention Centre shelter, and none were living at the shelter during the course of the program. Children were referred to the program by their parents, or in a few cases (n=7), their attendance had been mandated by Child & Family Services. Parents heard about this program through a variety of sources, such as friends, social services, or community advertising and chose to have their children participate. For the majority of children (59%), parents reported no Child Welfare involvement with the family.

Table 2

Description of Child Sample

Characteristic	Number of Children	Percent of Sample
Child's Sex		
Males	24	51.1
Females	23	48.9
Group Program Mandated		
Yes	7	14.9
No	40	85.1
Child Welfare Involvement Reported		
Yes	19	40.4
No	28	59.6
Child's Cultural Background		
White	37	78.7
Native	2	4.3
Asian or Pacific Island	1	2.1
Mixed Race	7	14.9

Tables 3 and 4 provide demographic information for each child in the sample. The 47 children in this sample were from 35 different families. Only slightly more than one half of the children (51%) did not have a sibling in this sample. Ten families had two children in the sample and one family had three children in the sample. Therefore, demographics are repeated for parents with multiple children in the study.

Table 3 provides descriptive information about the families participating in this study. Parents in this study ranged in age from 25 to 52 years. The parent completing the forms was generally the mother, however other caregivers were represented in the

sample, including fathers. Annual reported incomes of parents in this sample ranged from $7,200 to $60,000 per year.

Table 3

Description of Families by Child

Family Characteristic	Number of Parents	Percentage of Sample
Parent Completing Forms		
Mother	39	83.0
Father	4	8.5
Both Parents	2	4.25
Foster Parent	2	4.25
Parent Education		
Some High School	5	10.6
Completed High School	15	32.0
Some College	10	21.3
Completed College	12	25.5
Not Reported	5	10.6
Parent Employed		
Yes	37	78.7
No	10	21.3
Parent Relationship Status		
Married	12	25.5
Common-law	6	12.8
Single	8	17.0
Divorced	5	10.6
Separated with Contact	6	12.8
Separated without Contact	10	21.3
Parent Age (M/SD)	37.38	6.76
Family Income (M/SD)	$19,566	$13, 937

Table 4 illustrates reports of abuse gathered in questionnaire format from parents, not through an interview process. In several instances, sections of the form were not completed which leaves confusion about whether this lack of response indicates an absence of abuse or refusal to answer the questions. For example, some families (n=7) did not specify the existence of physical abuse between parents, however, marital abuse was assumed to exist in these homes which is corroborated by the fact that either a parent or Child Welfare sought treatment for the child. While the majority of reports indicted the father as committing the abuse towards the child and/or partner, some reports indicated the mother or both parents as the perpetrators. Parents reported that only 23% of the children (6 boys and 5 girls) in this sample had been the direct victims of physical abuse.

Table 4

Description of Abuse Histories for each Child

Abuse type by Perpetrator	Number of Reports	Percentage of Sample
Child Physical Abuse		
Mother	3	6.4
Father	5	10.6
Both	2	4.3
Other	1	2.1
None Reported	36	76.6
Child Emotional Abuse		
Mother	1	2.1
Father	17	36.2
Both	8	17.0
Other	1	2.1
None Reported	20	42.6
Child Sexual Abuse		
Father	2	4.2
Other	3	6.4
None Reported	42	89.4
Marital Physical Abuse		
Mother	1	2.1
Father	26	55.3
Both	13	27.7
None Reported	7	14.9
Marital Emotional Abuse		
Mother	1	2.1
Father	29	61.7
Both	6	12.8
None Reported	11	23.4

Measures

Several parent and child measures were utilized at both assessment times. Children in this study were administered three standardized self-report measures addressing affective variables of depression, anxiety, and posttraumatic symptoms and one knowledge form investigating information about abuse and safety planning. Parents were asked to complete an inventory about their child's behaviour (one per child) and an inventory about their own experiences of stress. As well, at the first assessment period parents were also asked to complete intake forms to provide background information about their family.

The internal consistency and reliability of these measures were not assessed in the present investigation, as the researcher only had access to the total scores. However, all of these instruments have been previously utilized with parent and children from homes characterized by spousal abuse. Excluding the intake forms and the children's knowledge form, four of the five remaining instruments are widely utilized standardized tests that have demonstrated good reliability and validity.

Child Self-Report Instruments

Children's Depression Inventory (Kovacs, 1992)

The Children's Depression Inventory (CDI) is a 27 item self-report measure for children aged 7-17 years, however. Kovacs (1992) noted that this instrument should be comprehensible to children as young as 6 years old. Administration of the CDI takes approximately 15 minutes and is preferably done individually. On each item children are provided with three statements and must choose the one that is most descriptive of

themselves in the past two weeks. Each of the three items is keyed 0, 1, or 2 and this provides a total score between 0 and 54. Scores are also provided for each of the 5 subscales: negative mood, interpersonal problems, ineffectiveness, anhedonia, and negative self-esteem. The CDI Manual provides T-scores, by gender and age group (Kovacs, 1992).

Kovacs (1992) reviewed the expansive literature on the CDI and concludes that it is a reliable and reasonably valid measure of depression for children. "Overall, the weight of the evidence gained from this voluminous literature is that the inventory assesses important constructs which have strong explanatory and predictive utility in the characterization of depressive symptoms in children and adolescents" (Kovacs, 1992, p. 38). The CDI Manual indicates good internal consistency, with reliability coefficients from .71 to .89. In regards to test-retest reliability, the CDI has been demonstrated to have an acceptable level of stability, with a range of .38 to .87 on studies with normal and clinical populations over a period of 1 week to 1 year (Kovacs, 1992). However, Kovacs (1992) also warned that lower CDI scores at a second testing should not be overly interpreted as several studies have detected a significant drop in CDI scores at a second testing.

The CDI has been utilized in numerous studies examining children exposed to marital violence (Hughes, 1988; Hughes et al., 1989; Lehmann, 1997; Sternberg et al., 1993). Lehmann (1997) compared CDI means between those children meeting the criteria for PTSD and those who did not, in a sample of children exposed to marital violence. The PTSD group was found to have significantly higher levels of depressive

symptoms on the CDI than the non-PTSD group. Several of the studies have found differences within samples of children exposed to marital violence in relation to whether they have experienced physical abuse. Sternberg et al. (1993) discovered differences between a sample of children exposed to marital violence and a comparison group of children, however, no differences were found in the marital violence group between those children who had been abused physically and those who had not. However, two studies (Hughes, 1988 and Hughes et al., 1989) did not find any significant differences on the CDI between samples of children from homes characterized by interparental violence and comparison groups from nonviolent homes.

The CDI Manual (Kovacs, 1992), states that T-scores at or above 66 are clinically significant, as this score places the individual at approximately the 93rd percentile in relation to normative data. This cut-off point (T-score $\geq$66) will be utilized in the present study to indicate clinical levels of depression according to the total CDI score.

Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1985)

The Revised Children's Manifest Anxiety Scale (RCMAS) is a 37 item self-report form that assesses the level and nature of anxiety in 6- to 19-year olds. Children must circle either "yes" or "no" in response to whether each statement is generally descriptive of them. This measure can be administered individually or in a group and is completed in approximately 15 minutes. The RCMAS provides a Total Anxiety raw score between 0 and 28. Scores are also provided for the four subscales: physiological anxiety, social concerns and concentration, worry and oversensitivity, and a lie scale. The RCMAS

manual provides T-Scores for the Total Anxiety score according to the child's age and gender.

Reynolds and Richmond (1985) presented numerous studies that have utilized the RCMAS with children in clinical and non-clinical samples. "Reliability and validity of the RCMAS as a measure of chronic anxiety in children seems well established by the existing literature" (Reynolds & Richmond, 1985, p. 41). The RCMAS manual reviews numerous studies and found internal consistency coefficients of .78 to .85 for the total anxiety score. Reynolds and Richmond (1985) illustrated the test-retest stability of the RCMAS with data from two studies of elementary school children. These studies garnered coefficients of .68 over a 9-month interval and .98 over a period of 3 weeks.

The RCMAS has been utilized to investigate anxiety in samples of children exposed to marital violence. Two studies have found significantly higher Total Anxiety T-scores for children exposed to marital violence in relation to a comparison group, however, no significant differences were discovered between those children who had been abused and those who had not within the marital violence group (Hughes, 1988; Hughes et al., 1989).

For the purposes of this study T-scores of 67 or above on the Total Anxiety score are deemed to be at the clinical level. T-scores in this range ($\geq$67) fall at approximately the 95th percentile according to the normative data provided in the RCMAS Manual (Reynolds & Richmond, 1985).

Angie/Andy Cartoon Trauma Scales (Praver, Pelcovitz, & DiGiuseppe, 1998)

The Angie/Andy Cartoon Trauma Scales (ACTS) is a relatively new instrument designed to measure trauma-related sequale of prolonged, repeated abuse in children aged 6 to 12. "The Angie/Andy measure features a cartoon-based format, which is aimed at facilitating understanding for young children who may lack the sophistication to complete most self-report measures" (Praver, DiGiuseppe, Pelcovitz, Mandel, & Gaines, 2000, p. 273). The ACTS was designed to provide children with a safe, non-threatening means of communicating their answers. A child views a cartoon girl or boy who is displaying traumatic stress symptoms, while the administrator reads each of the 44 items. Children are asked how often they feel, think, or act like Angie or Andy and may reply by simply pointing to their answer on a thermometer. The thermometer provides a visual cue to the potions of frequencies which are an objective 4 – point scale labeled (a) never, (b) just a few times, (c) some of the time, (d) a lot of the time. Administration of the ACTS took approximately 20 to 30 minutes.

Previous measures of Posttraumatic Stress symptoms in children have explored information about a discreet traumatic event that is viewed as an anchor to explore childrens' experiences prior to, and in particular, after that event. However, in situations of chronic or repeated exposure to violence there is no clear anchor event to refer to (Praver et al., 2000). An exception to this format is the Trauma Symptom Checklist for Children (TSCC) which is an instrument that can be used to explore chronic trauma in children aged 8 to 16 years old and which has been demonstrated to have good reliability and validity (Nader, 1997; Praver et al., 2000). However, Praver et al. (2000) identified

the need for a valid and reliable non-threatening instrument that provides information about chronic exposure to violence with younger children. "The Angie/Andy measure was developed to provide a focus for the complex nature of young children's subjective accommodations to on-going, prolonged trauma and abuse" (Praver et al., 2000, p. 275). The ACTS is comprised of seven subscales: avoidance of stimuli, re-experiencing, dissociation, dysregulation, system of meaning, self-perception, and somatization. These themes coincide with the DSM-IV-TR criteria for PTSD and with additional symptoms identified by Nader (1997), as prevalent in children exposed to ongoing trauma.

Although research efforts are currently underway, to-date no studies have been published on this version of the ACTS (Multi-Health Services, personal communication, 2001). Praver et al. (2000) utilized a previous research version of the ACTS, an 87- item scale with identical format, with children categorized into four groups: intrafamilial, extrafamilial, combined trauma (intrafamilial and extrafamilial), and a nontrauma group. In this study trauma referred to either physical abuse, sexual abuse, witnessing violence, or multiple forms of these experiences. On each of the subscales the three trauma groups scored significantly higher than the nontrauma group and general support was found for expected differences between each of the three trauma groups. As well, there was a high correlation between the ACTS and the degree and frequency of exposure to violence (Praver et al., 2000). "Angie/Andy showed excellent internal consistency, with preliminary evidence for construct and concurrent validities" (Praver et al., 2000, p. 282).

The ACTS provides a total score between 44 and 176. Interpretive information is provided for the ACTS total score for research and exploratory purposes. The guidelines

categorize scores into 5 levels ranging from "not a concern" to "should raise serious concern". For the purposes of this study the clinical cutoff point for the total score on the ACTS will be 76, as scores at this level and above are considered to be of concern (Praver, Pelcovitz, & DiGiuseppe, 1998).

Pre-Post Child/Teen Questionnaire/Interview

The Pre-Post Child/Teen Questionnaire/Interview (Appendix B) is a condensed version of the knowledge form utilized by Marshall et al. (1995) to investigate children's understanding of violence before and after a group treatment program. The version of the Pre-Post Child/Teen Questionnaire/Interview utilized in this study was adapted by staff at the YWCA Sheriff King Family Violence Prevention Centre and consists of two parts. The first section investigates children's knowledge about what actions constitute "abuse" and then explores children's attributions for the responsibility of abuse in the home. The second part of the form identifies children's repertoire of safety planning skills. Therefore, this measure addresses the three main areas of "subtle symptoms" identified by Jaffe et al. (1990) that may disrupt emotional and cognitive development of children exposed to marital violence. The Pre-Post Child/Teen Questionnaire/Interview provides a total score out of 17, with higher scores indicating greater levels of knowledge.

Parent Report Instruments

Intake and Child History Forms

The Intake Form (Appendix C) is a questionnaire that provides demographic information about the family. The Child History Form (Appendix D) is completed for

each child in the program (not just for each family) and provides qualitative information about forms of abuse that the child has experienced directly and indirectly. These forms were developed by staff at the YWCA Sheriff King Family Violence Prevention Centre and are part of the regular intake process for the children's group treatment program. The Intake and Child History Forms were only completed at the initial assessment time.

Child Behaviour Checklist (Achenbach, 1991)

The Child Behaviour Checklist (CBCL) has been repeatedly identified as the most utilized instrument in empirical investigations of the impact of marital violence on children (Barnett et al., 1997; Holden, 1998; Jaffe et al., 1990). The CBCL is parent-report form that assesses children's competency and problems in a standardized format. The first twenty questions on the CBCL inquire about a child's competence in their activities, social interactions, and school performance. The second portion of this measure investigates concerns about the child through 118 specific problem questions and 2 open-ended problem questions. Parents generally complete this form in about twenty minutes. The CBCL provides a total competence score and a total problem score. As well, scores for two components of the total problem score, Internalizing behaviours (i.e. anxiety, depression) and Externalizing behaviours (i.e. aggression) are also provided.

Achenbach (1991) notes that assessments on the CBCL should be at least two months apart to provide sufficient opportunity for behavioural change to develop and be identified. This amount of time between administrations also minimizes the possibility of "practice effects" which is the tendency for scores on rating scales to decline over brief test-retest intervals (Achenbach, 1991). Despite some "practice effects" the test-retest

reliability of the CBCL has been demonstrated by a mean test-retest r=.87 for the competence scales and .89 for the problem scales over a one week interval. As well, mean scores did not shift beyond chance expectations in studies with intervals of one or two years (Achenbach, 1991). The CBCL Manual also provides strong evidence of construct, content, and criterion-related validity, as well as good internal consistency (Achenbach, 1991).

The CBCL has been used in the majority of studies exploring the impact of interparental violence on children (for example, Davis & Carlson, 1987; Graham-Bermann & Brescoll, 2000; Hughes et al., 1989; Jaffe et al., 1985; Jaffe et al., 1986a; Jaffe et al., 1986b; Levendosky and Graham-Bermann, 1998; O'Keefe, 1994b; Sternberg et al., 1993). Most of these studies have uncovered significant differences between children exposed to marital violence and children from non-violent homes on one or more of the total competence, total problem, Internalizing, or Externalizing scores. Significantly higher rates of clinical levels in these scores compared to normative data are also a common finding. However the findings have not been consistent, particularly in regards to gender differences. In the reviewed studies with children of marital violence, the CBCL is the only standardized instrument which was utilized as a pre- and post-test measure in group treatment evaluations (Jaffe et al., 1988). However, that study did not find significant differences on the CBCL between the two time periods.

For the purposes of the present study the most stringent criteria suggested by the CBCL Manual are used; a total problem, Internalizing, and Externalizing T-score of ≥ 63 and a total competence T-score of ≤ 37 is considered to be at the clinical level

(Achenbach, 1991). Children with scores in these clinical ranges are in the tenth percentile of normative data according to the CBCL Manual (Achenbach, 1991).

Parenting Stress Index (Abidin, 1995)

The Parenting Stress Index (PSI) consists of 120 items assessing stress variables, particularly those impacting the parent-child relationship. The majority of questions require the respondent to rate the extent to which they identify with a statement on a 5-point likert scale (strongly agree to strongly disagree). The PSI takes approximately 20 minutes to complete and provides 4 main scores: Total Stress, Child Domain, Parent Domain, and Life Stress. The Child Domain questions gather information about the parent's perception of their child's characteristics, while the Parent Domain examines basic parent characteristics and family context variables. The Life Stress score addresses situational factors affecting the parent, such as the death of a relative or the loss of a job.

Abidin (1995) identified correlation coefficients for test-retest reliability for the PSI Total Stress score to range between .65 and .96 over intervals of 3 weeks to 1 year. In regards to internal consistency, reliability coefficients for the two domains and the Total Stress score were .90 or greater for the normative sample (Abidin, 1995). The PSI Professional Manual also reviews hundreds of studies that have utilized the PSI, including numerous research efforts examining family violence contexts. Abidin (1995) stated that these studies "provide evidence for the construct and predictive validity of the PSI" (p. 36).

Two studies have specifically utilized the PSI to investigate parental stress in battered women (Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998).

Both of these studies found that marital violence was associated with higher levels of parenting stress. Holden and Ritchie (1991) identified significant differences in overall stress scores between battered women and a comparison group of mothers matched for socioeconomic status. As well, as a group the PSI scores of the battered women were found to be at a clinical level according to norms provided by the PSI Professional Manual. Levendosky and Graham-Bermann (1998) found that Child Domain and Parent Domain scores on the PSI were significantly predicted by both psychological and physical abuse of the mother.

Percentile scores based on normative data are provided in the PSI manual for the Total Stress and subscale scores. The PSI Manual indicates that scores at, or above, the 85th percentile are considered to be "high scores" (Abidin, 1995, p. 5). The 85th percentile will serve as a cut-off point to delineate clinical levels for the Total Stress ($\geq$258), Parent Domain ($\geq$148), Child Domain ($\geq$116), and Life Stress ($\geq$14) scores in the present study.

Group Treatment Program

The YWCA Sheriff King Family Violence Prevention Centre in Calgary provides services, shelter and counselling to women, men and children who have witnessed, experienced, and/or perpetrated abusive behaviour in intimate relationships. The group intervention addressed in this study is provided for children in the community who have witnessed and / or experienced domestic abuse, including physical, financial, sexual, emotional, and / or psychological abuse. The children's program (see Appendix E for outline) was based on the work of Terr (1995) which is focused on addressing

posttraumatic stress issues in children by creating a safe and trusting therapeutic environment so that children can express their thoughts and feelings, as well as share their experiences. There is a strong psychoeducational aspect to the program, such as information about appropriate identification and expression of feelings, safety planning, problem-solving, and education in regards to definitions of emotional, sexual, and physical abuse. As well, children are taught relaxation exercises and encouraged to use them as needed. At least one parent of each child in the group intervention program was required to attend a corresponding parenting group at the same time. The parenting program focused on relationship building between the parent and child, and education about positive discipline practices.

No changes were made to the numbers of participants or composition of groups that are normally offered by the YWCA Sheriff King Family Violence Prevention Centre. Children were accepted into the groups on a first-come basis, regardless of age, gender, race, or any other variable. The children were grouped by age (ages 6-7, 8-9, 10-11, 12-13). There were two groups of 6-8 children per age bracket with a male and female facilitator assigned to each group. An effort was made to provide different groups to siblings. The group intervention ran for an hour and a half, once a week for a period of ten weeks. Facilitators were employees of the YWCA Sheriff King Family Violence Prevention Centre and have a Bachelor or Masters degree in social work, psychology, or a related degree.

Table 5

Frequency of Total Number of Sessions Attended by Child

Total Number of Sessions Attended	Number of Children	Percent of Children
0	4	8.5
1	5	10.6
2	1	2.1
3	1	2.1
4	2	4.3
5	2	4.3
6	2	4.3
7	7	14.9
8	9	19.1
9	9	19.1
10	5	10.6
TOTAL	47	100.0

In addition to receiving the group intervention, children, perceived by group facilitators or their parents to be in particular distress, had the opportunity to access supplementary support in the form of individual play therapy. Over the course of this study, two children were provided this service. Several of the children registered in the program completed the initial assessment measures but attended few, or in some cases, no group sessions (Table 5). Such a high rate of attrition is common for this program, as reported by staff at the YWCA Sheriff King Family Violence Prevention Centre.

Procedure

Parents were asked to complete the Consent Form and the Intake Form, as well as a Child History Form for each child enrolled in the program. Parent and child measures were taken the week prior to the commencement of the groups and then again at the ninth week of the intervention. Child measures were administered individually and this took approximately 40 minutes at both times. The parents' protocol took approximately 2 hours at Time 1 and an hour and 20 minutes at Time 2. However, some parents were given the CBCL and PSI to complete and return. Parent and child measures were administered by the facilitators of the group programs at the YWCA Sheriff King Family Violence Prevention Centre. In addition to the parent and child measures, each child's school teacher was contacted and mailed out the Child Behaviour Checklist – Teacher Report Form (C.B.C.L.-T.R.F.) (Achenbach, 1991) at both times. However, very few (2) forms were returned, and this measure was not investigated as originally planned.

Incomplete assessments were taken for some children and parents at both times, due to a variety of reasons. The most common source of incomplete data was the failure of parents to return completed measures that they were allowed to take home with them. As well, the irregular attendance of many children meant that several children who had not dropped out of the program missed the final assessment period. The high attrition rates in the group program also contributed to the lack of data at Time 2. Reasons for not completing the program included: father objecting to mother's enrollment of the children, children apprehended from the family by Child Welfare, and changes in parental schedules. In one instance, a child was withdrawn after the fourth session as the

parent was concerned that the child was becoming "too upset" by the group experience. Another child was withdrawn prior to the commencement of the program as the parent decided that the child had not witnessed enough violence to warrant attending the group. Once all of the information was collected by staff at the YWCA Sheriff King Family Violence Prevention Centre, the researcher was provided with anonymous scores and the completed instruments remained on file at the agency for therapeutic purposes.

CHAPTER FOUR: RESULTS

The analyses are presented in five sections. First, descriptive statistics are presented for each of the parent and child measures. Secondly, frequencies of scores in the clinical ranges are identified for both assessment periods by the number of children meeting this criteria and the percent of the sample this represents. The third section presents the bivariate correlations between measures at Time 1. Next, three separate between group differences are examined at Time 1. Analyses of variance are run according to the child's level of posttraumatic stress symptoms (clinical or non-clinical level on the ACTS), whether the child was reported to have been physically abused, and on the basis of gender. Finally, a paired t-test is utilized to examine shifts in scores on child and parent measures between Time 1 and Time 2.

Descriptive Statistics

Descriptive statistics for each of the parent and child measures are presented below for Time 1 (Table 6) and Time 2 (Table 7). The mean score, standard deviation, and range are provided, as well as the range of scores possible for each of the scales. The range of potential scores for the CBCL, CDI, and RCMAS T-scores vary somewhat according to age and/or gender, therefore the greatest possible range is presented.

Table 6

Descriptive Statistics for Time 1

Score	N	M	SD	Range	Range of Scale
CBCL					
Total Competence T-Score	39	42.5	7.80	29-59	10-80
Internalizing T-Score	39	66.5	8.54	46-82	31-100
Externalizing T-Score	39	60.3	12.12	37-87	30-100
Total Problem T-Score	39	64.7	9.17	46-80	23-100
CDI T-score	46	47.3	12.71	35-82	35-100
RCMAS T-score	46	46.0	12.17	24-73	18-92
ACTS total score	47	76.9	28.54	44-161	44-176
Knowledge total score	46	10.2	2.54	5-15	0-17
PSI					
Child Domain Score	42	125.8	23.87	80-182	47-235
Parent Domain Score	42	137.0	28.51	85-195	54-270
Life Stress Score	42	19.4	11.60	0-42	0-79

Table 7

Descriptive Statistics for Time 2

Score	N	M	SD	Range	Range of Scale
CBCL					
Total Competence T-Score	21	45.8	6.88	30-60	10-80
Internalizing T-Score	21	59.7	10.17	43-78	31-100
Externalizing T-Score	21	53.4	4.82	46-63	30-100
Total Problem T-Score	21	56.6	8.51	45-72	23-100
CDI T-score	29	45.0	9.72	35-78	35-100
RCMAS T-score	29	44.2	16.05	18-84	18-92
ACTS total score	29	68.3	24.75	45-140	44-176
Knowledge total score	30	13.1	1.48	10-15	0-17
PSI					
Child Domain Score	23	112.3	23.54	78-154	47-235
Parent Domain Score	23	132.7	27.8	74-187	54-270
Life Stress Score	23	16.0	8.56	4-35	0-79

Frequencies of Clinical Levels

Table 8 provides the frequencies of scores on the ACTS at both assessment periods according to the guidelines provided for research purposes. Scores on the ACTS between 76 and 176 indicate clinical concern. In this sample, 19 children at Time 1 (40.4%) and 8 children at Time 2 (27.6%) were in this range.

Table 8

Frequency of Total Scores on the ACTS at Time 1 and 2

		Time 1		Time 2	
Range	Interpretation	N	%	N	%
44-65	Very Low Score (not a concern)	19	40.4	17	58.6
66-75	Within Normal Limits	9	19.2	4	13.8
76-85	Elevated Score (should raise some concern)	4	8.5	2	6.9
86-105	Very Elevated Score	7	14.9	4	13.8
106-176	Markedly Elevated Score	8	17.0	2	6.9
TOTAL		47	100.0	29	100.0

As expected, children in this sample were found to have high rates of clinical levels according to parents' reports on the CBCL of their competence (T-score $\leq$37) and problem behaviours (total, Internalizing, an Externalizing) (T-score$\geq$63). Table 9 shows the percentages of the sample with scores that fall in the clinical ranges, on the CBCL. In the normative data provided by Achenbach (1991) scores in the clinical range are only found in 10% of the population. In this sample at Time 1, 33% to 66% of the children were in the clinical range on each of the 4 CBCL scores. These rates decreased at Time 2, with between 4% to 47% of the children being in the clinical range on each scale.

Contrary to expectations, rates of CDI and RCMAS clinical scores were not distinctly above rates for normative data. Clinical scores on the CDI (T-score$\geq$66) and the RCMAS (T-score$\geq$67) are found in the normative data provided by the manuals in 7%

and 5% of the population respectively. Rates of clinical scores in this sample on the CDI and RCMAS are only marginally above these percentages at Time 1 and below them at Time 2.

Table 9

Frequency of Clinical Scores on the CBCL, CDI, and RCMAS at Time 1 and 2

	Time 1			Time 2		
T-Scores	N	N in Clinical Range	% in Clinical Range	N	N in Clinical Range	% in Clinical Range
CBCL						
Total Competence Score	39	13	33.3	21	3	14.3
Externalizing Problems	39	18	46.2	21	1	4.8
Internalizing Problems	39	26	66.7	21	10	47.6
Total Problem Score	39	25	64.1	21	6	28.6
CDI	46	5	10.9	29	1	3.5
RCMAS	46	3	6.5	29	4	13.8

Of the 39 children in this sample with complete data for the CDI, RCMAS, CBCL, and ACTS at Time 1, only 6 children (15%) had *no* scores in the clinical range on any of these measures. It is also noteworthy that none of the 39 children were at the clinical level on *all* of these scores.

As expected, rates of parent scores in the clinical range on the PSI were markedly elevated in relation to normative data. Table 10 displays parents' self-ratings of stress according to the PSI for each parent. The cutoff for clinical scores on this measure falls

at the 85th percentile, with only 15% of the population expected to score in the clinical range. On all three subscales of the PSI, at both times, clinical scores are found in 30% to 68% of the sample.

Table 10

Frequency of Clinical Scores on the PSI at Time 1 and 2

	Time 1 (n=32)		Time 2 (n=20)	
PSI scale	N	Percent	N	Percent
Parent Domain	10	31.3	6	30.0
Child Domain	19	59.4	7	35.0
Life Stress	22	68.8	12	60.0

Note. Scores on this chart are for each *different* parent participating in the study, parent scores are *not* repeated for the number of children involved in the sample.

Table 11 displays the frequency of clinical scores on parent and child measures for the 18 children with complete data sets for both assessment times. Therefore, removing the attrition factor within this study, it becomes clear that many scores dropped out of the clinical range by the second assessment period. These shifts are particularly evident in regards to total and Externalizing behaviour problems, as well as parental stress in the Child Domain.

Table 11

Frequency of Clinical Scores at Time 1 and 2 (n=18)

	Time 1		Time 2	
T-Scores	N in Clinical Range	% in Clinical Range	N in Clinical Range	% in Clinical Range
CBCL				
Total Competence Score	3	16.7	1	5.6
Externalizing Problems	5	27.8	0	0.0
Internalizing Problems	8	44.4	6	33.3
Total Problem Score	9	50.0	4	22.2
CDI	1	5.6	1	5.6
RCMAS	1	5.6	2	11.1
ACTS	6	33.3	6	33.3
PSI				
Parent Domain	7	38.9	5	27.8
Child Domain	12	66.7	5	27.8
Life Stress	9	50.0	9	50.0

Bivariate Correlations

According to expectations, significant correlations (at the $p<0.01$ level) were evident between children's ratings of their anxiety, depression, and posttraumatic stress symptoms (Table 12). However, contrary to expectations, no significant relationship was evident between the children's report scores (CDI, RCMAS, and ACTS) and parents' rating of their child's Internalizing problems on the CBCL.

Table 12

Correlation of RCMAS, CDI, CBCL Internalizing, and ACTS scores at Time 1

	Pearson Correlation Coefficients			
Scores	Internalizing T-Score	CDI T-Score	RCMAS T-Score	ACTS Score
Internalizing T-Score	-			
CDI T-Score	.008	-		
RCMAS T-Score	.093	.704**	-	
ACTS Score	.163	.760**	.729**	-

**= significant correlation at the 0.01 level

Table 13 shows significant correlations between parent stress and measures of children's functioning at Time 1. As expected, parental stress was positively correlated to children's anxiety, depression, posttraumatic stress symptoms, and both Internalizing and Externalizing behaviour problems. However, no significant correlation was found between parental stress and ratings of child competence.

Table 13

Correlations Between Parent Stress and Child Measures at Time 1

Scores	Pearson Correlation Coefficient Total PSI Score
CBCL	
Total Competence T-Score	-.148
Externalizing Problems T-Score	.506**
Internalizing Problems T-Score	.485**
CDI T-Score	.426**
RCMAS T-Score	.474**
ACTS Score	.372*

* = significant correlation at the 0.05 level
**= significant correlation at the 0.01 level

Analyses of Variance

Table 14 displays a series of between group analyses of variance according to whether children's scores on the ACTS were in the clinical or non-clinical range for Time 1. A one-factor MANOVA was conducted for ACTS group X CBCL T-scores (total competence, Externalizing problems, Internalizing problems, and total behavior problems). As predicted, significant main effects were found for total competence ($F(1,37) = 4.54$, $p<.05$), Externalizing problems ($F(1,37) = 7.28$, $p<.001$), and total behavior problems ($F(1,37) = 17.65$, $p<.01$). However, no significant difference was found for Internalizing problems ($F(1,37) = 0.63$, $p=.432$).

A one-factor MANOVA was conducted for ACTS group X CDI and RCMAS T-scores. These two measures were included in the same analysis grouping as they have

already been demonstrated to be highly correlated. The RCMAS and CDI T-Scores were severely positively skewed, so a logarithmic transformation was conducted for each of these variables (Tabachnick & Fidell, 1983). As expected, significant main effects were found for the CDI (F (1,44) = 24.23, $p<.001$) and the RCMAS (F (1,44) = 22.89, $p<.001$).

Contrary to expectations, a one-factor ANOVA revealed no significant differences for ACTS group X total knowledge scores (F (1,44) = 3.59, $p=.065$). A one-factor MANOVA was conducted for ACTS group X PSI scores (Child Domain, Parent Domain, and Life Stress scores). No significant differences were revealed for Child Domain (F (1,40) = 0.39, $p=.138$), Parent Domain (F (1,40) = 2.95, $p=.536$), and Life Stress scores (F (1,40) = 3.18, $p=.082$).

Table 14

Scores at Time 1 according to the Child's Status on the ACTS

Scores	ACTS Non-Clinical Levels			ACTS Clinical Levels			F	df
	N	M	SD	N	M	SD		
CBCL								
Total Competence T-Score	24	44.5	7.5	15	39.3	7.4	4.54*	1, 37
Externalizing T-Score	24	55.0	10.3	15	68.9	9.8	17.65***	1, 37
Internalizing T-Score	24	65.6	7.3	15	67.9	10.4	0.63	1, 37
Total Problem T-Score	24	61.8	8.6	15	69.3	8.2	7.28**	1, 37
CDI T-Score	28	41.4	6.0	18	56.5	15.0	24.23***	1, 44
RCMAS T-Score	28	40.3	9.1	18	54.9	11.0	22.89***	1, 44
Total Knowledge Score	28	10.8	2.7	18	9.3	2.1	3.59	1, 44
PSI								
Child Domain Score	26	121.5	22.4	16	132.8	25.2	0.39	1, 40
Parent Domain Score	26	134.8	27.5	16	140.5	30.7	2.95	1, 40
Life Stress Score	26	21.9	11.5	16	15.4	10.9	3.18	1, 40

*=significant difference at $p<.05$
**=significant difference at $p<.01$
***=significant difference at $p<.001$

Table 15 presents the results of between group analyses of variance for each of the measures according to whether or not the child was reported to have been physically abused. Contrary to predictions, no main effects were found with these analyses. A one-factor MANOVA was conducted for physical abuse X CBCL T-scores (total competence, Externalizing problems, Internalizing problems, and total behavior problems). No significant differences were found for total competence (F (1,37) = 3.42, p=.072),

Externalizing problems ($\underline{F}$ (1,37) = 0.03, $\underline{p}$=.855), Internalizing problems ($\underline{F}$ (1,37) = 0.95, $\underline{p}$=.337), and total behavior problems ($\underline{F}$ (1,37) = 0.03, $\underline{p}$=.861).

A one-factor MANOVA was conducted for physical abuse X CDI, RCMAS, and ACTS scores. These measures were included in the same analysis grouping as they have already been demonstrated to be highly correlated. The RCMAS and CDI T-Scores were severely positively skewed, so a logarithmic transformation was conducted for those two variables (Tabachnick & Fidell, 1983). No significant differences were found for the CDI ($\underline{F}$ (1,44) = 5.09, $\underline{p}$>.05), RCMAS ($\underline{F}$ (1,44) = 0.29, $\underline{p}$=.595), and the ACTS ($\underline{F}$ (1,44) = 2.16, $\underline{p}$=.149).

A one-factor ANOVA revealed no significant differences for physical abuse X total knowledge scores ($\underline{F}$ (1,44) = 0.03, $\underline{p}$=.878). Finally, a one-factor MANOVA was conducted for physical abuse X PSI scores (Child Domain, Parent Domain, and Life Stress scores). No significant differences were revealed for Child Domain ($\underline{F}$ (1,40) = 0.04, $\underline{p}$=.685), Parent Domain ($\underline{F}$ (1,40) = 0.17, $\underline{p}$=.835), and Life Stress scores ($\underline{F}$ (1,40) = 0.04, $\underline{p}$=.846).

Table 15

Scores at Time 1 according to Reported Child Physical Abuse Status

	No Child Physical Abuse			Child Physical Abuse				
Scores	N	M	SD	N	M	SD	F	df
CBCL								
Total Competence T-Score	28	43.9	8.1	11	38.9	6.0	3.42	1, 37
Externalizing T-Score	28	60.1	10.9	11	60.9	15.4	0.03	1, 37
Internalizing T-Score	28	67.3	7.3	11	64.4	11.2	0.95	1, 37
Total Problem T-Score	28	64.9	8.8	11	64.3	10.5	0.03	1, 37
CDI T-Score	35	45.1	10.9	11	54.6	15.7	5.09	1, 44
RCMAS T-Score	35	45.5	11.2	11	47.7	15.3	0.29	1, 44
ACTS Score	35	72.7	24.7	11	86.9	37.1	2.16	1, 44
Total Knowledge Score	35	10.2	2.6	11	10.1	2.5	0.03	1, 44
PSI								
Child Domain Score	31	124.9	23.1	11	128.4	26.9	0.04	1, 40
Parent Domain Score	31	136.4	28.2	11	138.6	30.7	0.17	1, 40
Life Stress Score	31	19.2	11.3	11	20.0	13.0	0.04	1, 40

*=significant difference at $p<.05$

Table 16 displays the results of a series of analyses of variance for each measure according to the child's gender. As predicted, a significant main effect was revealed for total competence (F (1,37) = 5.92, $p<.05$). However, no significant difference was found for Externalizing behavior problems (F (1,37) = 2.29, $p=.139$).

External to the hypothesis, boys were found to have significantly higher levels of Internalizing behaviour problems and total behaviour problems compared to girls. The mean scores for boys' on all four reported dimensions of the CBCL were in the clinical range. Even though the boys' scores were significantly higher than girls' for

Internalizing behaviour problems, it is important to note that the mean of the girls' Internalizing scores was also in the clinical range.

Table 16

Scores at Time 1 According to Gender

	Boys			Girls				
Scores	N	M	SD	N	M	SD	F	df
CBCL								
Total Competence T-Score	20	39.7	7.3	19	45.4	7.4	5.92*	1, 37
Externalizing T-Score	20	63.2	10.6	19	57.4	13.2	2.29	1, 37
Internalizing T-Score	20	69.1	8.4	19	63.7	8.0	4.17*	1, 37
Total Problem T-Score	20	68.3	7.9	19	61.0	9.1	7.18*	1, 37
CDI T-Score	24	47.5	11.8	22	47.1	13.9	.01	1, 44
RCMAS T-Score	24	45.6	11.8	22	46.5	12.8	.06	1, 44
ACTS Score	24	74.9	23.7	22	77.4	33.2	.09	1, 44
Total Knowledge Score	24	9.9	2.6	22	10.5	2.6	.06	1, 44
PSI								
Child Domain Score	21	129.9	22.6	21	121.7	25.0	1.24	1, 40
Parent Domain Score	21	139.4	24.1	21	134.6	32.7	.29	1, 40
Life Stress Score	21	20.8	11.2	21	18.0	12.1	.61	1, 40

* =significant difference at $p<.05$

Paired T-Test

A paired t-test was conducted to examine differences on each measure over time with the 18 participants who provided complete data for both Time 1 and Time 2 (Table 17). As expected, significant differences were found for Externalizing problems, Internalizing problems, and total behavior problems. However, no significant differences

were found for the CDI, RCMAS, and ACTS scores. As predicted, a significant increase was evident on the total knowledge score. The expected significant difference was found for parental stress on the Child Domain. However, there were no significant differences on the Parent Domain and Life Stress scores.

In addition, Internalizing behaviour problems was the only score of child functioning with a mean in the clinical range and the mean fell out of the clinical range at Time 2. The PSI mean scores for the Child Domain and Life Stress scores were in the clinical range for this sample at Time 1. Parent ratings of their Life Stress was the only score with a mean in the clinical range at Time 2.

Although complete data for this analysis was only available for 18 participants there was no change, in terms of the significant differences ($p \leq .01$) discovered between pre- and post-measures, when a paired t-test was conducted with all available data (i.e. incomplete data sets at both times).

Table 17

Scores at Time 1 and 2 (n=18)

Scores	Time 1 M	Time 1 SD	Time 2 M	Time 2 SD	t	df
CBCL						
Total Competence T-Score	46.7	7.4	46.4	6.9	.22	17
Externalizing T-Score	58.1	9.0	53.3	5.1	3.54**	17
Internalizing T-Score	64.1	8.5	58.2	10.0	4.10***	17
Total Problem T-Score	62.0	8.9	55.7	8.5	5.84***	17
CDI T-Score	46.3	11.8	45.9	10.5	.31	17
RCMAS T-Score	46.8	11.1	44.3	14.9	.96	17
ACTS Score	71.6	24.0	67.2	20.4	1.46	17
Total Knowledge Score	9.8	2.7	12.9	1.4	-5.32***	17
PSI						
Child Domain Score	122.8	20.0	107.8	22.0	4.30***	17
Parent Domain Score	132.4	28.3	128.9	27.9	1.24	17
Life Stress Score	15.2	9.6	14.1	7.9	.51	17

* =significant difference at p< .05
**=significant difference at p<.01
***=significant difference at p<.001

CHAPTER FIVE: DISCUSSION

The present investigation examined parental stress and child variables of affect, behaviour, and knowledge, in families seeking treatment regarding exposure to marital violence. Normative data was utilized as a source of comparison for scores in this sample and rates of clinical scores were examined. Several subgroups within the sample were compared in regards to significant differences on each of the measures. Correlations between several measures were also investigated. Finally, this sample of children and parents were re-assessed after accessing a treatment intervention, in order to determine if any significant changes had occurred.

Current Findings

Characteristics of this Sample at Time 1

The expectation that rates of clinical scores would be elevated in this sample for parent and child measures compared with normative data was largely supported. For children this finding was most evident with parent ratings of their child's functioning on the CBCL. More than half of this sample were in the clinical range on the CBCL (top tenth percentile) for Internalizing behaviour problems (66%) and total behaviour problems (64%) at Time 1. Forty-six percent of this sample were in the clinical range for Externalizing behaviour problems and 33% were in this range in terms of the total competence score at Time 1. These rates are similar to those found with samples of children from shelters. For example, O'Keefe (1994b) reported CBCL scores for 185 children living at a shelter for battered women and found that 45% of the sample were rated by their mothers to have Externalizing behaviour problems in the clinical range and

for Internalizing behaviour problems 57% were reported to be in the clinical range. Therefore, the current sample of children from the community accessing a treatment program are similar to children living in shelters in terms of parent reported behavior.

Children's self-ratings on measures of anxiety and depression were found to be only marginally above the rates of clinical levels found in the normative data. Five children (10%) had scores in the clinical range on the CDI, which is expected to be found in approximately 7% of normative samples according to the CDI Manual. Similarly, 6% of children displayed clinical levels on the RCMAS at Time 1, compared to 5% of normative samples in the RCMAS Manual. This finding is consistent with the Hughes et al. (1989) study that found children living in shelters to have higher scores on the CDI and RCMAS than a comparison group, but not at a significant level. Increased anxiety in this population of children may be more evident when measures more specific to family violence (assault anxiety or concerns of safety) are utilized (Graham-Bermann, 1996; Lehmann, 1997).

The second research expectation was confirmed, as parent ratings of their own stress reflected extremely high rates of clinical concern. High scores were found in 31% of the sample on the Parent Domain, 59% of the sample on the Child Domain, and over 68% of the sample in ratings of life stress. Scores at this level are only expected in 15% of normative samples. These results are somewhat elevated in relation to PSI scores reported in other studies with mothers residing in shelters (Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998). For example, Holden and Ritchie (1991) reported that the battered women ($\underline{n}$=37) in their sample had a mean total PSI score at the

80^{th} percentile of normative data and the present sample was at approximately the 87^{th} percentile. Therefore, although the parents in the current study were not living in a shelter their parenting stress scores reflected levels of distress equal to, or higher than battered women seeking shelter.

As expected, children's ratings of their posttraumatic stress symptoms on the ACTS were found to correlate highly ($p<0.01$) with children's self-reports of anxiety and depression. This finding was predicted by Praver et al. (2000) who suggested that this version of the ACTS would significantly correlate with standardized measures of anxiety and depression. However, the fourth expectation was not supported as the ACTS, and the other two child self-report measures (CDI and RDMAS), were not significantly correlated with parent's ratings of their children's Internalizing behaviour problems on the CBCL. Therefore, at least in terms of internalizing concerns, parent and child perceptions of the child's functioning do not appear to be related in this sample. This discrepancy was also noted by Sternberg et al. (1993) who found that parents' ratings of children's Internalizing behaviour problems were poorly correlated with children's CDI scores. There appears to be growing evidence that parents and children in this population do not have similar perceptions of internalizing concerns (Spaccarelli et al., 1994). However, in the present study the parents appear to have identified *more* internalizing problems in their children than the children reported for themselves. A possible explanation for this is that trauma symptoms associated with ongoing trauma, such as repression, dissociation, and self-anesthesis (Terr, 1991) contribute to children under-reporting their own symptoms.

Parents' rating of their own stress was positively correlated with several measures of child functioning as predicted. Parental stress and parent perceptions of children's Internalizing and Externalizing behaviour problems were significantly correlated ($p<0.01$). Children's self-reports of depression ($p<0.01$), anxiety ($p<0.01$), and posttraumatic stress symptoms ($p<0.05$) were also significantly correlated with parental stress. The only variable that did not significantly correlate with parental stress was the parent rating of children's competence. This strong association supports previous findings linking parental stress and child behavioural concerns (Levendosky & Graham-Bermann, 1998; Holden & Ritchie, 1991). However, the present finding contradicts the hypothesis posited by Kilpatrick and Williams (1998) who suggested their study did not find parental stress to be related to posttraumatic stress symptoms due to the use of a child-report measure. The results of the present study find child *and* parent reports of child functioning relate to parental stress and this result provides credibility to theories, such as the family disruption hypothesis, that cite parental stress as a factor in children's poorer functioning. Although the pattern of effect is unclear, this finding suggests that the child and parent systems influence each other. This is an important consideration for treatment planning.

As expected, numerous group differences were uncovered between those children in the sample with scores of clinical concern on the ACTS and those children with ACTS scores in the normal range. Compared to their peers, children with clinical scores on the ACTS had significantly higher scores of depression, anxiety, total problem behaviours, and Externalizing behaviour problems. As well, these children were found to have

significantly lower levels of parent-rated competence in relation to children with ACTS scores in the normal range.

Although it is unclear if any of the children scoring in the clinical range on ACTS meet the criteria for a DSM-IV-TR diagnosis of PTSD, the present findings are similar to those found by Lehmann (1997). In that study of children exposed to marital violence, children meeting the PTSD criteria were found to have higher levels of depression and assault anxiety than the rest of the sample. An unexpected finding between the ACTS groups in this sample was a significant difference between the two groups in regards to Externalizing behaviour problems, but not with Internalizing behaviour problems in this sample. Graham-Bermann and Levendosky (1998a) found that compared with other children of marital violence, children who experienced PTSD symptoms had higher CBCL Internalizing and Externalizing scores. The present result seems counterintuitive, but corresponds to the lack of correlation between parent's ratings of Internalizing problems and children's ratings of their depression, anxiety, and posttraumatic stress disorder in this investigation.

No significant difference was found on the knowledge score between those children with ACTS scores of concern and those with ACTS scores in the normal range. Two studies examining PTSD in samples of children exposed to marital violence have examined children's attributions about the violence. Lehmann (1997) found that children who met the PTSD criteria had significantly more negative attributions, such as self-blame and guilt and posited that these perceptions may exacerbate PTSD symptoms. However, Kilpatrick and Williams (1998) found that while several children in their

sample had symptoms of self-blame and guilt, these symptoms did not significantly relate to the level of PTSD the child was experiencing. As well, the lack of significant difference between the two groups in terms of parental stress in the present investigation corresponds with Kilpatrick and Williams (1998) finding that maternal stress did not contribute to the level of PTSD reported by the child.

No support was found for the seventh research question, as no significant differences were discovered between children who had and who had not been physically abused in this sample. Several trends for poorer functioning in the physically abused group were evident, particularly with the total competence, CDI, and ACTS scores. It is possible that the small number of children in the physically abused group (n=11) contributed to the lack of significant findings.

Empirical research generally finds that on measures of adjustment, the scores of children exposed to marital violence fall between those of normative samples and those of children who are exposed to interparental violence, as well as being victims of physical aggression by their parents (Davis & Carlson, 1987; Hughes et al., 1989). However, some studies have found no significant differences between children of interparental violence who have, and have not, been physically abused in terms of anxiety and depression (Graham-Bermann and Levendosky, 1998b; Hughes, 1988; Hughes et al., 1989; Sternberg et al., 1993). These studies found significant differences on the RCMAS and CDI between children of marital violence and comparison groups, but not on the basis of physical abuse within the marital violence group. Hughes et al. (1989) found

that the physical abuse and non-physical abuse groups differed significantly in terms of total behaviour problems on the CBCL, but not on any of the other CBCL scales.

The ACTS scores were expected to be elevated in the physical abuse group. Preliminary findings by Praver et al. (2000) with a previous version of the ACTS found differences between children exposed to marital violence on the basis of whether or not they had been physically abused. However, Graham-Bermann and Levendosky (1998a) did not find child physical abuse status was correlated with posttraumatic stress variables. Another interesting finding was the lack of significant differences on the parental stress scales according to child physical abuse status. Therefore, parents who abused their child, or whose spouse abused the child, did not rate their parenting of the child as a significantly more stressful experience.

It is important to recognize that the categorization of these two groups (abused and non-abused) in the present study was based on qualitative information provided on intake forms by parents. By sorting the children into two groups on this basis numerous experiential factors are overlooked.

> Dichotomizing children into groups of 'abused' versus 'non-abused', (for example) can readily disguise the range of experiences children may have had, and may fail to account for variables such as psychological development or compensatory factors that may mediate the impact of these diverse experiences. (Wolfe and Jaffe, 1991, p. 295)

Support was found for one of the two predicted gender differences. As expected, boys were reported by their parents to have significantly lower levels of competence than

the girls in this sample. Despite a trend for boys to have higher scores on the Externalizing scale as expected, this was not a significant difference between the two groups. Both boys and girls in this study had mean Internalizing scores in the clinical range, however, boys in this sample did have significantly elevated Internalizing and total problem scores compared to girls. This finding was unexpected as girls and boys exposed to marital violence generally have similar levels of Internalizing behaviour problems (McDonald & Jouriles, 1991). The lack of gender differences in regards to posttraumatic stress symptoms in this sample is consistent with all of the previous investigations that have been reviewed (Graham-Bermann and Levendosky, 1998a; Kilpatrick & Williams, 1998; Lehmann, 1997).

Changes in this Sample from Time 1 to Time 2

As expected, parents' ratings for their children on Internalizing, Externalizing, and total problem behaviours were significantly lower at Time 2. Another encouraging finding was the decrease in the percentages of children with scores in the clinical range on each of the behaviour problem scales. This finding suggests a "clinically significant" result, in addition to statistical significance, as the children were more likely to be functioning within the identified range for the general population (i.e. within the non-clinical range) (Jacobson, Follette, & Revenstorf, 1995). The most drastic shift was found with the Externalizing problem score; 46% of the sample at Time 1 had scores in the clinical range compared to 4% at Time 2. Admittedly, the possibility of selective attrition may account for the dramatic changes in these percentages. However, marked

shifts were still evident in terms of the total and Externalizing behaviour problems when only the 18 children with complete data sets were taken into account.

The lack of control group in this study precludes definitively attributing these behavioural changes solely to the treatment intervention. There is a possibility that some, or most, of the changes evidenced are due to a spontaneous "recovery" over time (Wolfe et al., 1986). Even if this latter suggestion were true, the ability for children to rebound is a remarkable finding. However, there are several reasons to believe that the child and/or parent treatment interventions influenced these findings. It is interesting that the present results contrast with the only other study utilizing the Child Behaviour Checklist as a pre- and post-measure with a 10 week group intervention for children exposed to marital violence (Jaffe et al, 1988). That study followed the same number of children (N=18) in a similar age group (7- to 13-years) and despite some positive trends, they did not find any significant changes according to parent ratings on the CBCL scores. It is important to note that the children in the Jaffe et al. (1988) study had generally been separated from marital violence for a year or more, which is not true for all children in the present investigation. Perhaps these children were more stable as a group and not as easily influenced by intervention. However, CBCL scores for children in both studies were similar at Time 1.

The present finding of significant differences in terms of children's behavioural scores on the Child Behaviour Checklist (total, Internalizing, and Externalizing) appears to be in contrast with another study as well. Wolfe et al. (1986) did not find differences on any of the behaviour problem scores between a group of children, aged 4- to 13- years

living in a shelter (n=23) and former residents of the shelter who had been living in a stable, nonviolent home for at least 6 months (n=23). The lack of significant differences in that study also suggest that time alone is not sufficient to produce behavioural changes. Therefore, the present finding of significant behavioural changes appears to be unique.

A further source of support for attributing these changes to intervention efforts is the heterogeneity of experiences for families in the present study. Children entering this program are living in diverse situations (i.e. with or without on-going marital violence) and are likely at a variety of stages in terms of dealing with their experiences. Therefore, the finding of significant behavioural changes seems less likely to be attributable to effects of time.

Another consideration in the interpretation of the present findings is that standardized tests have a tendency to be scored closer to the mean upon second administration (Achenbach, 1991; Kovacs, 1992). However, there was a 10-week interval between assessment times in this study that surpasses the minimum two-month waiting period suggested by Achenbach (1991) to minimize these "practice effects". It seems improbable that the significant differences discovered between the two times are solely attributable to this tendency.

Contrary to expectations, no significant differences were found between the two times on the CDI, RCMAS, and the ACTS. However, a trend was evident for each of these scores to be lower at Time 2. As well, there was a decrease in the percentage of the sample with clinical scores on each of these measures between Time 1 and Time 2. This

finding indicates that while children did not seem to perceive any shifts in their affective domains, parents have identified significant changes in children's behavior.

The tenth research question was confirmed, as a significant difference in the knowledge score between the two assessment times was evident. Like several other evaluations of group treatment programs this study demonstrated that children made significant shifts in their knowledge of forms of abuse, responsibility for abuse, and safety planning (Jaffe et al., 1988; Marshall at al., 1995; Wagar & Rodway, 1995). Children's increased knowledge scores appear most likely influenced by the group intervention. This is an encouraging finding as increased knowledge and attitudinal shifts may serve as protective factors for children (Graham-Bermann, 1998; Jaffe et al., 1990).

The final research expectation received partial support, as parent self-ratings of stress in the Child Domain significantly decreased between Time 1 and Time 2. This finding appropriately corresponds to parent's ratings of significantly less total behaviour problems for their children at Time 2. Although no significant differences were uncovered on the other two PSI scales, it should be noted that the percentage of clinical scores on the PSI decreased for the Parent Domain, Child Domain, and Life Stress scores between the two assessment times.

It may be that parent's reports of their own decreased stress in the Child Domain and their reports of their child's improved functioning are in some way related. This seems particularly likely since children did not report significant differences for themselves on any of the measures of affect. However, it is unclear how parental stress and parental perceptions of child behavior are influencing each other. It is possible that

children's reduced problem behaviors (perhaps due to the group intervention) may have led to decreased stress for their parents. Another possibility is that parents are experiencing less stress (perhaps due to the parenting group) and this shift has led to a less severe judgment of their child. "It seems possible that maternal reports of children's behavioural and emotional problems may more truly be a reflection of the emotional well-being and coping level of mothers than an accurate indication of the children's level of difficulty" (Kilpatrick & Williams, 1998, p. 327). A final possibility is that these two pathways to change are both responsible for the significant findings at Time 2.

Limitations of the Study

The lack of explicit information gathered about children's exposure to abuse was a limitation in the present investigation. A more complete understanding of the duration, frequency, and timing of violence directed towards themselves or others in their home is needed to provide a clearer picture of the factors influencing children's well-being (Wolfe et al., 1985). In addition to family violence variables, gaining more detailed knowledge of accompanying verbal, psychological, and/or sexual abuse may have provided valuable contextual information. In this study only children reported to be physically abused were specifically examined, however, intake forms reported that the majority of children in this sample (57%) were also the target of emotional abuse. The literature's equivocal findings regarding the behavioural, emotional, and cognitive functioning of children exposed to spousal abuse, are at least, in part, attributable to a lack of recognition of these factors. A more complete history of children's individual experiences in an interview format (i.e. the Conflict Tactics Scale) may have better

represented the diversity of experiences and further clarified the multifonality evident in this sample of children.

A larger sample size would have provided an opportunity to further examine the role of various demographic variables. For example, our limited understanding of patterns of effects based on age and gender in the functioning of children exposed to marital violence is, at least partially due to the relatively small sample sizes that are insidious to this research area (Holden, 1998). Although the high attrition rate over the course of the group intervention was a major limiting factor in the interpretation of results, this phenomenon is not unusual in programming for children exposed to marital violence (Peled & Edleson, 1998, 1999; Tutty & Wagar, 1994). Children who attended sporadically or who dropped out over the course of the ten weeks may have been living in particularly adverse family situations. Therefore, lowered rates of clinical scores at the second assessment time may be biased by the type of individuals who left the program. However, the trends on the CBCL and PSI remained consistent when just the 18 children with complete data for both times were examined, so this result is not called into question by the rate of attrition. As well, significant differences were found on several scales for those 18 children between the two assessment times. It possible that these families were particularly ready for change, and these results may not have been found if all the participants remained in the program and had been evaluated at the second time.

Another methodological drawback in this study is the lack of a comparison and/or control group, with normative data on standardized instruments providing the only source of comparison. Normative data was effective in identifying significant deviance in this

sample, however, it was not as informative as a secondary group would have been. Information gathered about children's level of functioning at Time 1 would have been more illuminating if it had been possible to compare the findings with scores for children from nonviolent homes with similar socioeconomic backgrounds. However, forming comparison groups without violence in the home is a difficult task, as there appears to be a tendency in the general population to deny the existence of physical abuse (Randolph & Conkle, 1993). A control group over the course of the treatment intervention would have also been particularly valuable, however, assessing traumatized children without offering immediate services poses ethical concerns.

The current study utilized both parent and child reports on instruments to gather data. The disparity between these two sources of information highlights the need to access as many views as possible when conducting research on children's functioning. In addition, the use of child reports provides a clearer picture of interaction between variables. As evidenced in the current investigation, the use of child self-reports removes the possibility that results are confounded by heavy reliance on parental perceptions of their children's emotional and behavioural health. Reports from the children's schoolteachers on the CBCL-TRF would have provided valuable information about the differences and similarities of their ratings of a child as compared to the parent's. Some researchers have noted that parent reports were significantly correlated with other adult observers (Graham-Bermann & Levendosky, 1998a; Randolph & Conkle, 1993), while others found that mothers perceived their children to be more maladjusted than adult observers or child self-reports (Hughes and Barad, 1983; Sternberg et al., 1993).

A unique characteristic of this study is that the participants were not residing in a shelter, and most never had. Samples consisting of children and mothers residing in women's shelters may be biased by the fact that the family is in the midst of a crisis and transitions. Women in shelters may also have endured particularly severe abuse and may have fewer supports than other abused women. For these reasons, children living in shelters may display decreased levels of functioning compared to samples of children exposed to marital violence living in the community (Barnett et al., 1997; Fantuzzo, DePaola, Lambert, Martino, Anderson, and Sutton, 1991; Holden et al., 1998; Jaffe et al., 1990; Lehmann & Mathews, 1999; Spaccarelli et al., 1994). This phenomenon has been referred to as the "shelter effect" (Fantuzzo & Lindquist, 1989, p. 89).

The sample in the present study may be biased as well, in that although it is composed of children from families living in the community, for the most part, they are seeking out treatment for themselves and their children. Two particularly unique characteristics of this sample were the presence of several fathers as the reporting parent and a much lower percentage of reported concurrent child physical abuse (23%) than generally reported in this population of children (Appel & Holden, 1998; Hughes & Fantuzzo, 1994). However, despite the differences in group sampling and composition, children's scores on the CBCL at Time 1 are similar to the majority of studies utilizing samples from shelters for battered women. For example, the T-Scores on the Child Behaviour Checklist behaviour problem scales (total, Internalizing, and Externalizing) are comparable to those found with physically abused and non-abused children exposed to marital violence (T-Score=58-65) (Hughes et al., 1989; Wolfe et al., 1986). In the

present study, 46% to 64% of the sample had scores on the three behaviour problem scales in the clinical range at Time 1. These percentages are elevated in relation to normative data (approximately 10% of the population at clinical levels) and comparable to rates generally found in studies of children in maritally violent homes (Barnett et al., 1997; McDonald & Jouriles, 1991; O'Keefe, 1994b).

The sample under investigation in this study is one of convenience as the families were mostly self-selected to a treatment program. Therefore, the findings are not necessarily representative of the general population of children exposed to marital violence. Another limiting factor is that the correlational nature of the data presented here precludes the interpretation of causal relationships among the variables investigated. This is a cross-sectional study, and no information is available regarding childrens' pre-trauma functioning. These limitations prevent unequivocal conclusions about the effects, and subsequent impact, of spousal abuse on children. Despite some methodological concerns, and limited generalizability beyond this sample, the findings do contribute to our knowledge of children exposed to marital violence.

Implications for Treatment

The high rate of scores in the clinical range in this sample highlights the need for treatment intervention programs for both children and parents. The significant shifts in children's behaviour and knowledge ratings, as well as the decrease in parental stress, are encouraging findings. As previously mentioned, parent reports of their decreased stress in the child domain and of their children's decreased behavioural concerns are likely related. However, it is unclear how the child and parent factors influenced each other.

Parent reports of their own, and their children's improvement may have been influenced by the children's group, the parenting group, other unidentified variables, or a combination of these. However, it seems likely that both parent and child interventions were important sources of information and support for families.

Children's increased knowledge regarding abuse and safety planning seems most likely influenced by the group intervention. This finding supports previous program evaluations and confirms that education about abuse and safety planning can be effectively taught. This finding is particularly exciting as cognitions and attitudes may have long-term protective value (Graham-Bermann, 1998; Jaffe et al., 1990). A developmental psychopathology approach emphasizes the interaction of individual characteristics with the environment. Therefore, even if children continue to live with marital violence, changes in cognitions and attitudes may lead to more positive outcomes.

Current theories suggest that children's adjustment is affected by marital violence directly through their observations, and indirectly by factors such as maternal parenting stress. Therefore, even though marital violence is the root of both pathways of affect, interventions focusing on reducing parenting stress are likely to have a positive impact on child adjustment (Levendosky & Graham-Bermann, 1998). "In fact, parenting by the nonviolent parent may serve as a potential protective/vulnerability factor for children regardless of the mechanisms through which they are affected by the violence" (Levendosky & Graham-Bermann, 1998, p. 385). Therefore, intervention efforts for both parents and children are likely to positively influence long-term outcomes for children exposed to marital violence.

Implications for Research

The Angie/Andy Cartoon Trauma Scales (ACTS) was significantly correlated with standardized measures of anxiety and depression in this sample. As well, children's groupings based on clinical and non-clinical ACTS scores successfully differentiated other measures of children's functioning according to parent reports and child self-reports. In fact, whether a child's ACTS score was in the clinical or non-clinical range was more predictive of their functioning than the child's gender or whether the child was reported to have been physically abused.

The ACTS appears to be a promising tool to assess for symptoms associated with exposure to on-going trauma in young children. The self-report nature of this instrument is particularly important, as parents' own traumatic reaction may affect the accuracy of their reporting of their children's symptoms (Nader, 1997; Yule & Cantebury, 1994). The ability of this instrument to discriminate children on the basis of other measures assessing emotional and behavioural concerns in this sample may have implications for future research. The ACTS may be a useful instrument to address the PTSD theory previously discussed that suggests behavioural outcomes for children exposed to marital violence may simply be an extension of trauma symptoms.

Future studies should consider the methodological limitations previously discussed, including the need for larger sample sizes, a comparison group, and more detailed history taking methods. The importance of utilizing both parent and child reports is highlighted in this investigation and future research efforts should include as many sources of information about children's functioning and symptom presentation as

possible. The use of multiple informants for determining violence and maltreatment within the home may also be quite valuable. For example, the use of additional assessment tools for assessing childrens' perspectives of existing marital violence (O'Brien et al., 1994; Sternberg, Lamb, Dawud-Noursi, 1998). Program evaluations should incorporate standardized measures of children's functioning in addition to measures of knowledge and attitudes. Such investigations, if utilizing appropriate control groups, may provide illumination about the pathways to positive change for children exposed to marital violence.

There is clearly a need for longitudinal studies with children from violent homes that can provide a clearer picture of the patterns of effect and directions of causality. Such studies may help to clarify the pathways of direct and indirect sources of adversity stemming from marital violence that lead to deleterious outcomes for some children. This type of research effort would also provide an opportunity to further contextualize children's experiences and provide greater understanding of maladaptive processes in development.

Consistent with a developmental psychopathology approach, further investigation into those children growing up in maritally violent environments who do *not* develop problems would be of particular interest. For example, in the present study at least six children did not have *any* scores in clinical range. Studying adaptive outcomes under adverse circumstances may also provide vital information for future treatment efforts. The study of children's resilience has identified several factors, such as perceived social support, locus of control, and attributional style that may have protective value for

children facing adversity. Further research focusing on children's cognitions, attitudes, and attributions, as well as their appraisals of their situation, would be an interesting avenue of exploration. "It is these protective factors – about which we know little – that may lead us to design more effective interventions to minimize the impact of violence on children" (Edleson, 1999, p. 865).

Summary

The present investigation described the functioning of a group of children and parents accessing treatment intervention programs at two points in time. This study addressed several of the methodological issues affecting previous investigations with children exposed to marital violence (Edleson, 1999). The sample was comprised of families living in the community, not those in crisis residing in shelters. Co-occurring forms of abuse, towards adults and children, were identified and child physical abuse was specifically examined. Child and parent report measures were utilized and the majority of instruments were widely recognized standardized assessment tools. As well, this study utilized a relatively new instrument specifically designed for use with young children exposed to on-going family violence.

The children and parents in this sample were found to have similar levels of concern found in previous studies with samples of children and mothers residing in shelters for battered women. The rates of clinical scores in this sample highlight the need for resources available to families struggling with family violence who remain in the community. As well, the strong association between children's mental health and parental stress was confirmed in this sample, and this finding points to the need for

intervention efforts aimed at both children and parents. The results of this study also support the need for professionals to consider both trauma and behavioural symptoms when preparing interventions and further research. The prevalence of trauma symptoms identified by children in this sample further underscores the detrimental effects associated with exposure to marital violence and supports the categorization of this experience as a form of emotional and/or psychological abuse for children.

This study is unique, as significant shifts were evidenced in childrens' and parents' functioning on standardized measures over the course of treatment efforts targeting each of these groups. These results suggest optimism for immediate, and long-term, well-being for some children exposed to marital violence. Efforts to address childrens' emotional, behavioural, and trauma symptoms, as well as their knowledge and attitudes about violence, may also serve to reduce the likelihood of the perpetuation of family violence in subsequent generations.

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Appendix A

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FACULTY OF EDUCATION

Department of Educational Psychology
Education Tower/Room 302
Telephone (403) 220-5651
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Consent Form

Evaluation of a Group Intervention for Children who have Witnessed Family Violence.
Karen MacMillan B.A., Dip. Ed.

The University of Calgary

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

1. The purpose of this research is to evaluate the effectiveness of the children's group counselling program at the YWCA Sheriff King Family Violence Prevention Centre and Sheriff King Home. All children accessing this program in the Fall term (September, 2000 to November, 2000) will be asked for permission to have their information released anonymously to this researcher. This information includes the pre- and post- treatment measures addressing feelings, behavior, and knowledge completed by children, parents, and teachers.

2. The pre-treatment measures will be completed in the week prior to the commencement of the group sessions and the post-treatment measures will be completed during the ninth group session. Parents will be asked to complete four questionnaires at the initial time and then two at the follow-up point. Your child's teacher will be asked to complete a questionnaire at both of

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FACULTY OF EDUCATION

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these times. Children will complete four questionnaires, as well as be interviewed at the initial point. In the follow-up the children will be asked to complete three questionnaires.

3. The questionnaires and interview that your child will participate in deal with sensitive information and they have the potential to be upsetting to some children. The facilitators administering these assessments are aware of this possibility and will be offering further treatment and support to any children they are concerned about. If you feel that your child is distressed by these procedures, please notify the facilitators so that arrangements can be made to provide additional treatment and support for your child.

4. The information collected from participants will be utilized by the staff at the YWCA Sheriff King Family Violence Prevention Centre and Sheriff King Home for therapeutic purposes. There will be no identifying information for research purposes. Information will be coded with numbers and individual results will be combined to form group data, ensuring that individuals cannot be identified. Research data will be kept in a locked file for a period of three years, after which time it will be destroyed.

5. No additional costs will be incurred due to participation in this research. Fees based on a sliding scale will be charged as per the YWCA Sheriff King Family Violence Prevention Centre and Sheriff King Homes' usual policy for participation in this group. No remuneration will be provided to participants.

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6. This investigator will, as appropriate, explain to your child the research and his or her involvement, and will seek his or her on-going cooperation throughout the project.

7. Summaries of the research findings will be provided to the YWCA Sheriff King Family Violence Prevention Centre and Sheriff King Home upon the completion of this study These will be available to be picked up or mailed out to you upon request.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. Your continued participation should be as informed as your initial consent, so you should feel free to ask for further clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact any of the following people:

Karen MacMillan
Master of Counselling Student
University of Calgary
Research Investigator
283-6173

Dr. Lisa Harpur
Thesis Supervisor
University of Calgary
220-7573

Jean Dunbar
Children's Program Manager
YWCA Sheriff King Family Violence Prevention Centre
294-3662

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If you have any further questions regarding your rights as a possible participant in this research, please contact Mrs. Patricia Evans, Research Services Office, Room 602 Earth Sciences, telephone: 220-3782.

Participant's Signature Date

Investigator and/or Delegate's Signature Date

Witness' Signature Date

A copy of this consent form has been given to you to keep for your records and reference.

Appendix B

YWCA Family Violence Prevention Centre & Sheriff King Home

Pre-Post Child/Teen Questionnaire/Interview

Your Leader will Fill in This Section or Give You Instructions

First Name: _____ **Last Name:** _____

Date Test Administered: _____ ☐ Pre-Test ☐ Post-Test
Day Month Year

Program: _____

Gender of Child: ☐ F ☐ M **Date of Birth:** _____
Day Month Year

1. Sometimes adults act in ways that are hurtful to other people in the family. When this happens we call it abuse. Here is a list of things that a grownup or parent in the family may do. Which would you say are abuse?
   a) If a grownup or parent in the family hits someone in the family with their fist, is it abuse?
      Yes _____ Don't Know _____ No _____
   b) If a grownup or parent in the family slaps someone is it abuse?
      Yes _____ Don't Know _____ No _____
   c) If a grownup or parent in the family calls someone names is it abuse?
      Yes _____ Don't Know _____ No _____
   d) If a grownup or parent in the family tells someone they will hurt them, is it abuse?
      Yes _____ Don't Know _____ No _____
   e) If a grownup or parent in the family breaks things in the house, is it abuse?
      Yes _____ Don't Know _____ No _____
   f) If a grownup or parent in the family touches someone in their private place on their body, even if they say "No", is it abuse?
      Yes _____ Don't Know _____ No _____
   g) If a grownup or parent in the family hurts the family pet is it abuse?
      Yes _____ Don't Know _____ No _____

	True	Not Sure	False
2. Some hitting (between a dad and a mom) is OK.	T	NS	F
3. A fight (yelling, screaming, hitting) can clear the air and settle things.	T	NS	F
4. Sometimes, adults do things they deserve to be hit for.	T	NS	F
5. Sometimes children are the cause of parent's abusive behaviour/fights.	T	NS	F
6. Children are to blame if dad hits mom.	T	NS	F

B. **Safety planning**
   If the adults in your house were fighting, what would you do? (Circle as many as you wish)
   a) Nothing
   b) Try to stop them
   c) Go to your room
   d) Phone 911
   e) Phone someone else
   f) Go to a neighbour, friend, relative

Reference. Adopted from Children's Aid Society: group treatment program for child witnesses of women abuse.

Appendix C

YWCA Sheriff King Family Violence Prevention Centre
CHILDREN'S PROGRAM ~ INTAKE FORM (pre-group)

Name of person completing form: _____ Date: _____

Relationship to child: _____ Birth Date: _____

Address: _____

Phone: (Home): _____ (Business): _____

Emergency Name & Number: _____

Currently Employed: Yes ☐ No ☐ Occupation: _____

Source of Income if not Employed: _____ Amt. Of Income: _____

Highest level of educ. completed: _____ Partner's Educ.: _____

Which of the following categories best describes your cultural background?

White ☐ Native ☐ Black or African☐ Mixed Race☐ Asian or Pacific Island ☐

Or: _____

Are you or have you ever been involved with community agencies, groups or programs? Yes☐ No☐ If so, which ones? Current: _____

Past _____

Purpose of other agency involvement: _____

Doctor's Name: _____ Phone No.: _____

Name of Children (first & last)	Age	D.O.B.	In program	Grade	Parents' names

In the child's family, who is / had attended any one of our group programs?

Name: _____ Group: _____ Dates: _____

Name: _____ Group: _____ Dates: _____

Are you currently: married ☐ common-law ☐ single ☐ divorced ☐

separated but with contact ☐ separated but no contact ☐ Other: _____

How long has this been your status? Months: _____ Years: _____

If you are currently in a relationship:

This partner's name _____

Partner's working status: full-time ☐ p/t ☐ on/call ☐ unemployed ☐ Other _____

Who, if anyone, is abusive in the relationship? _____

Does this partner know the child(ren) are being registered in this program? Yes ☐ No ☐ Unsure ☐

Alcohol or drug abuse problems - Please specify:

You: _____ Partner _____

Child Welfare Involvement? Yes ☐ No ☐

Name of Worker: _____ Phone _____

Reason for Child Welfare Involvement:

_____

Safety Issues

Is there a restraining order in place that involves the children? Yes ☐ No ☐

If YES, please provide details that your children's counsellors should be aware of.

Where did you hear about our agency: Radio ☐ Counsellor ☐ TV ☐ Phone Book ☐

Other _____ Who recommended that you access our children's program and why? _____

Appendix D

Part II: Child History ~ Two pages to complete ~

Note: ==> PLEASE COMPLETE A SEPARATE CHILD HISTORY FORM FOR EACH CHILD YOU ARE REGISTERING IN THE PROGRAM

Date:_____ Referring parent's name:_____

Name of child: _____ Contact phone number:_____

1. Are you divorced or separated from the child's other parent? Yes ☐ No ☐

   If Yes:

   a) When did you separate/divorce?_____

   b) How old was your child at the time? _____

   c) Number of separations from this partner?_____

   d) Who has custody of the child? _____

   e) Is or was this relationship abusive? Yes ☐ No ☐

   f) Who was abusive: _____

   g) Is the non-custodial parent supportive of his/her child attending this program? Yes ☐ No ☐

   h) Does the non-custodial parent have visitation and does s/he consistently use this privilege?

   _____

   i) Is the non-custodial parent willing to participate in program? Yes ☐ No ☐

   If yes, name and contact number:_____

   j) How do you think this will affect your child's participation in the program?

   _____

2. On a scale of one to ten how close do you feel to your child:

   0 ---------- 5----------10

   Not close at all Very close

3. On a scale of one to ten how close does your child feel to your current partner:

   0 ----------5----------10

   Not close at all Very close

4. Beyond relationship/marital violence, has your child experienced any traumatic events throughout his/her life (eg., a death, injury, separation, abuse by a non-parent figure, etc.)?

   _____

5. Is there anything else about your child that may be helpful for us to know?

   _____

6. Does your child have any special needs, allergies, etc.?_____

   _____

FAMILY RELATIONSHIPS:

All relationships experience conflict at one time or another. When conflict and anger are expressed in a way that is hurtful to others, this is called abuse. Abuse may be physical, emotional, sexual or financial in nature. If abuse has occurred in your family, this can have effects on children. It is helpful for your children's facilitators to know if your children have ever witnessed or experienced abuse.

Describe the kinds of abuse your child has witnessed or experienced?

Emotional: _____

_____

Age_____For how long? _____ Abusive party(s)_____

When was the last incident? _____

What was your child's response? _____

Response by significant adults in child's life _____

_____

Physical: _____

_____

Age_____For how long? _____ Abusive party(s)_____

When was the last incident? _____

What was your child's response? _____

Response by significant adults in child's life _____

_____

Financial: _____

_____

Age_____For how long? _____ Abusive party(s)_____

When was the last incident? _____

What was your child's response? _____

Response by significant adults in child's life _____

_____

Sexual: _____

_____

Age_____For how long? _____ Abusive party(s)_____

When was the last incident? _____

What was your child's response? _____

Response by significant adults in child's life _____

_____

Appendix E

YWCA FAMILY VIOLENCE PREVENTION CENTRE
& SHERIFF KING HOME

Children's Program
Program Agenda

Getting Acquainted

Meeting between children and facilitators
Completion of Pre-tests by children
Decoration of file folders to be used throughout group for artwork, handouts etc.

The following session topics are covered during the ten week program. However, each facilitator team will decide the most appropriate time to introduce each topic. The timing varies according to the needs of each group and its individual members. The group may spend more than one week on a given topic. The facilitator team will keep you updated on the group agenda as it progresses.

Session I: Getting to Know You

During this session the children will begin to get to know each other and the facilitators. They will start the process of building a safe and trusting environment in which they can express their thoughts and feelings.

Activities:

a) Exercises will be introduces to assist the children in sharing information about themselves. It is very important that the children understand the goals of the group and why they are there. The facilitators will explain the purpose of the group an provide an opportunity for the children to ask questions or discuss their thoughts and feelings regarding their participation.

b) Group Guidelines are required in order to provide a safe and caring environment for the children in which they can discuss their feelings and experiences. The children will brainstorm guidelines with the facilitators.

c) Brain Gym exercises are useful in giving children tools to acquire self-control and relaxation. Two exercises will be introduces each week. As the children become more familiar with them they will be able to utilize the exercises on their own when required.

Session II: Families

Many children have experienced significant stressors within the family environment. These may include witnessing and/or experiencing abuse within the family; significant losses through divorce, separation, multiple moves, foster care; stressors such as unemployment, poverty, addictions, illness, etc. The literature states that children need an opportunity to tell their stories in a supportive environment before they can begin the healing process.

Activities:
Different exercises will be introduces in order to facilitate this process for the children. Activities based on the family theme may include drawing the family, puppet play, creating wishes for the family, or describing family activities and roles.

Session III: Feelings
Children who have lived with family violence or other stressful circumstances often have difficulty identifying and expressing their feelings. During this session, the children will have an opportunity to explore their feelings about events in their lives, to begin to learn how to identify and label their feelings and to begin to develop appropriate ways to express their feelings. Learning about feelings is a very gradual process. Discussing past events can also bring up many anxieties for the children often leading to acting out behaviours. Brain Gym and boundary exercises will be reemphasized in order to provide tools to the children to keep themselves safe.

Activities
a) Check in will provide an opportunity to begin the discussion on feelings. Feeling Faces posters, Mood Charts, drawings and games can be used to facilitate this process.

b) Paper Dolls: In this exercise the children cut out a string of paper dolls. They then identify each doll as someone that is important to them. Stickers are sued to help the children verbalize the dynamics and feelings that occur between the identified people.

Session IV: Dreams
Children who have experienced or witnessed abuse often exhibit symptoms of anxiety such as nightmares, sleep difficulties, somatic complaints, etc. This session helps children to deal with the fear and anxiety of experiencing nightmares and to develop coping strategies.

Activities
The topic of dreams will be introduces to the children. The children may be asked to draw their dream or a story related to bad dreams might be read by the facilitators. The children will be lead carefully towards exploring the fears in their dreams and developing coping strategies to help them confront the fear. This might include visualizing a different ending to the dream or imagining a more positive dream. Additionally, children might create their own safety plan to cope with scary nightmares.

Session V: Losses and Wishes
This session will provide an opportunity for the children to explore the losses and changes they have experienced in their lives. Each child will deal with the feelings aroused in this session in a different way. The individuality of the children's reactions to this session should be respected and validated.

Activities
Activities will allow children opportunities to acknowledge their grief, say goodbyes and look toward their futures. Resources and supports available to children to help deal with their sadness will be discussed.

Session VI: What is Abuse
In this session, children will learn the definitions of physical, emotional and sexual abuse. The children will be encouraged to discuss the feelings they have associated with abuse. The topic of bullying might also be raised in this session.

Activities
A video such as "Super Puppy: Words Can Hurt" or "No More Teasing" is usually shown in this session. These videos both deal with the effect of emotional abuse. The children may also engage in role plays depicting the different types of abuse. The children will then be encouraged to discuss what the characters might be thinking, feeling and doing.

Session VII: Sexual Abuse
The children will gain a further understanding of sexual abuse and personal boundaries in this session. Resources and supports for children who have experienced sexual abuse will be introduced.

Activities
The video "Good Things Can Still Happen" is shown in this session. This is the story of tow children who have experienced sexual abuse and are dealing with its effects. The children also "build" their own personal space with yarn or masking tape in order to further understand the concepts of personal space and boundaries.

Session VIII: Responsibility for Violence/Safety Planning
This session will help children to understand that the perpetrator of violence is the one responsible for the abuse. Many children feel responsible for the abuse they witness between their parents. Blaming of others as the cause of abuse has often been role modeled for children making it difficult for they, themselves to take responsibility for their own choices and actions when angry. Children will also develop their own safety plan in this session in order to keep themselves safe in a dangerous situation.

Activities
Children will be lead through a discussion on responsibility for abuse. Various myths about abuse may also be discussed. The video "Tulip Doesn't Feel Safe" will be shown. This video outlines steps children can take to keep themselves safe when they are afraid. This plan is then implemented by a little girl and her brother as they witness abuse by their father towards their mother. After the video, the children make their own personal safety plan naming people they can call in an emergency.

Session IX: Anger/Problem Solving
This session will begin the process of assisting children in understanding and managing their own anger. They will learn alternative strategies in dealing with anger as will as

realistic and effective means of problem solving. A goal of this session is to help children take responsibility for their own anger and the choices they make when angry.

Activities
The children will discuss the feeling of anger and the ways people express it. They will be encouraged to explore what makes them angry and their own reactions including warning signs of anger and appropriate and inappropriate ways of expressing this feelings. Role plays may also be done that include different scenarios where children might have an angry response.

Termination Session: saying Good bye
Many of the children attending group have had multiple losses in their lives. Saying good bye for them may be difficult and anxiety producing. This session will provide an opportunity for children to say good bye in a healthy way where feelings of loss and sadness are respected and validated.

Activities
During the second last week, the children and facilitators planned a celebration to mark the end of group. This usually includes a special snack e.g. pizza, ice cream, cake. This celebration will include acknowledging feelings of sadness at saying good bye as well as validating the hard work and accomplishments achieved by the children while in group.