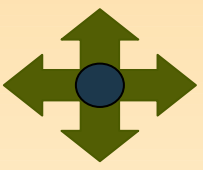
Children First

A Guide for Service Providers working with Children Exposed to Family Violence

May 2007

Manitoba Association of Family Violence Workers



RESOLVE
Research and Education for Solutions to Violence and Abuse

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Preface

There is no magic formula when it comes to counselling work or working with children. Each situation is unique as are the individuals involved. This guide, therefore, has been put together as a starting point for this type of work, offering suggestions for service providers to consider when working with children who have witnessed domestic violence. We encourage you to use this guide as a resource for your own work, to stimulate discussion with others, or as a place to begin developing new ideas, but it is in no way the final word on any of the topics included.

This guide is a reflection of what is currently considered good practice in the field, developed through collaboration between people working in the field and current related literature. In time, new ideas will be introduced and different methods will be preferred and recommended. It is important to remain open minded and current with new developments in order to continue to provide the best services possible.

One benefit from the development of this guide has been an opportunity for those involved to share and learn from each other. Those working in the field are encouraged to continue engaging in the wider conversation on this topic through reading, professional development, and connecting and sharing with others. The advantages of participating in and continuing this conversation are numerous, but most important of all, it will allow us to find new ways to promote and support the needs and interests of children, first.

I: Introduction

1. Purpose of the Manual

The purpose of this manual is to provide a resource for service providers working either directly or indirectly with children affected by intimate partner violence. It contains information that could be helpful in the following scenarios:

- Used as guidelines for the development of new children's programs and modification of existing programs.
- Writing proposals for children's programming.
- Policy makers and program funders may find the document useful in establishing their own guidelines or criteria for programming and evaluation.

The manual presents programming issues and considerations for children 12 years and younger. Developmental differences are noted as are methodologies or approaches appropriate to certain ages and/or developmental levels. Although the manual is focused on programming guidelines for children 12 years and younger, references are sometimes made for alternate methods or considerations for older children. A bibliography offers a variety of resources, including some for older children.

2. Healthy and Unhealthy Families

A) Healthy Families

Healthy families are characterized by a parenting style where parents make reasonable, age appropriate demands on their children and are highly responsive to their children's needs. The demands placed on children encourage them towards independence and maturity and set reasonable limits to facilitate self regulation. Children are encouraged to take part in family decision making and are listened to by parents. The message to children is that they are competent and effective agents in their world. Parents are warm, affectionate, supportive and protective. They serve as role models for the behaviours they are encouraging in their children. They are patient and rational when dealing with unreasonable demands from their children and provide clear and reasonable rules that are applied with consistency. Parents are continuously adapting to their children's increasing abilities and skills and thus their parenting practices change to match their children's developmental level. These parents respect the rights of children and expect respect from their children in return. Children in these types of families tend to be confident, independent, cooperative and self controlled. Often, they are happy, friendly, have high self esteem and good emotional and social skills. They are eager to master new skills and have higher academic interest and achievement (Berk, 2006).

B) Unhealthy Family Patterns

Maladaptive families may be characterized by parents who are unresponsive, overly demanding, make demands beyond the child's developmental level, or rejecting. These parents use force and physical punishment to ensure obedience and are often more focused on their needs rather than those of their children. Children in these families are often anxious, withdrawn and unhappy. Some become hostile, angry and defiant. Because parents do not involve them in decision making, many of these children are very dependent. Permissive parenting is also maladaptive and children from these families are often immature, have poor impulse control, are rebellious, overly demanding and non-achievers. Uninvolved parents ensure that the children's need for food, clothing and shelter are met but are emotionally detached and thus not warm, caring or affectionate. They demonstrate very little interest in their children's lives and activities and have minimal interaction with them. This may result from depression or being overwhelmed by stressors. At an extreme level this can lead to neglect. The children of uninvolved parents tend to have difficulty with self regulation, poor school performance, frequent substance use and problems with delinquency (Berk, 2006).

C) Family Violence

Family violence is a complex and multidimensional concept. It can involve a number of different family members and it is not limited to persons living in the home. There are also many forms of family violence such as

> **Physical abuse** - using physical force in a way that injures someone, or puts them at risk of being injured (Department of Justice, 2002).
> **Sexual abuse** - forced unwanted sexual activity, sexual coercion, or exploitation.
> **Neglect** - failure to provide the basic needs including food, clothing, medical attention, shelter, attention, and supervision (Berk, 2006).
> **Emotional abuse** - harming a person's sense of self, attacking a person verbally, criticism, threats, intimidation, social isolation, stalking, harassing (Department of Justice, 2002).
> **Witnessing violence** - In maladaptive families various forms of abuse may occur between parents. When children hear or see violence between their parents or other family members or even have an awareness that this violence is occurring, they themselves can become traumatized. The literature recognizes this witnessing of family violence as a form of emotional abuse.

Many of these forms coexist and within each of these forms, there exists a continuum of severity. For example, Johnson (1995) discusses two forms of violence: patriarchal terrorism that involves male partners controlling women through the violence, financial dependence, threats, isolation, and other forms of control; and common couple violence where conflicts occasionally get out of control and result in minor forms of violence that rarely escalate to more severe abuse.

Because researchers are adults and partner violence involves adults, most of the literature takes an adult perspective of the violence that occurs in the relationship. However, children will have their own perspective of the violence that takes place between their parents and/or other family members and its degree of severity. What may not be perceived as severe by partners (or researchers) from a child's view may be very severe and frightening. Their responses, both mental and physical, will be based on their perceptions. Each child's perspective must therefore be taken into account in counselling and service providers need to work to understand this perspective in order to understand the child's response and how best to approach counselling.

3. Core Beliefs

This document is guided by some core beliefs that are believed to be fundamental to providing services to children and helping them heal from their experiences with family violence. These beliefs are discussed below.

A) Healthy Families

Healthy families and relationships are characterized by mutual respect, dignity, equality and individual responsibility. These relationships nurture and support every individual's physical, emotional and spiritual wellbeing. Healthy families contribute to an environment were it is possible for each person to thrive and realize their full potential. Within healthy families individuals physical needs (food, shelter) and psychological needs (personal control, self worth, purpose) are met. They are free from oppression, discrimination, fear, violence and abuse.

B) Respect for the Rights of Children

As persons, all children have the same rights as others, including adults. The United Nations Convention on the rights of the Child in 1989 identified four broad categories of rights for children (Amnesty International Canada, 2006):

- Subsistence rights – the rights to food, shelter, rest, and health care.
- Developmental rights – the right for children to reach their full potential, to play and be educated.
- Protection rights – including the right to life, privacy, and protection from abuse, neglect and exploitation.
- Participation rights – the right to play an active role in community and political life, to express themselves and to be informed.

Individuals providing services to children need to be involved in protecting and advocating for these rights on the behalf of the children they are serving. They have to serve as examples, by respecting these rights themselves.

C) Use Respectful Language

The language used by individuals has a powerful direct and indirect effect by representing certain beliefs and perspectives. References made to children and their parents should be respectful of their rights and their experiences. One example is the use of the term “offender”, “batterer” or “perpetrator”. Although these are used in the literature, when interacting with children, the terms convey a message of blame and dehumanization. It also often assumes that the person who has used violence is always the father, leading to gendered language such as referring to the person who behaved violently as "he". While statistically it is more often a woman who is on the receiving end of domestic violence from a male partner, there will be times when it was the child’s mother or the child themselves who have used violence or behaved abusively. Thus, these terms may cause confusion and hurt feelings in children, which may be detrimental to their building a sense of trust in the service provider. The use of the term “person who has used violence” or “person who has behaved abusively” identifies the behaviour, not the person as undesirable. This type of language implies that the person is respected and that their behaviour can be changed.

Another caution is the use of the terms "victim" and "survivor" to refer to the person who has had violence used against them. The term "victim" can be disempowering and may deny the partner's own involvement in the violence. The children may not see their parent as a victim and/or it may not be helpful for them to see their parent in this way. The term "survivor" is respectful of their experience in the short term, but its continued use implies that they can never move beyond that experience.

Another example is the use of male and female pronouns. References to both plural (children) and singular (child) are made in the document. To avoid the awkwardness of always using “he/she”, the document alternates between “he” and “she”. As programming for children of both genders is served by this document, either of these terms are appropriate. It is important that any documents and reports produced be inclusive, appropriate, and representative in their choice of female and male pronouns. Individuals working with families need to be role models for positive and respectful behaviour, including how language is used.

D) Physical Discipline has a Negative Impact

Corporal or physical punishment is defined as the “intentional infliction of pain on the body for purposes of punishment or controlling behavior.” (Block, 2005). Current research indicates that physical discipline of children negatively impacts their sense of self, their mental health, social relationships, reasoning and problem solving capacity, and their understanding of the acceptability of the use of violence (Gershoff, 2002; Straus, Sugarman & Giles-Sims, 1997; Straus & Gelles, 1990; Voices for Children, 2003). Further, it can often lead to abuse, as disciplinarians lose control and go beyond legally accepted forms of physical punishment (Trocme, et al., 2001;Voices for Children,

2003). To avoid these negative outcomes, it is recommended that physical discipline not be used.

This document promotes the use of non-physical methods of discipline. It is recommended that service providers who are helping parents understand and deal with the effects of family violence on their children, also encourage and teach methods of discipline that do not include corporal punishment. Durrant (2005) states that professionals who support any form of physical punishment are put in the position of determining the line between acceptable and unacceptable forms of physical punishment. To avoid the potential difficulty in this task and the likelihood of sending mixed messages, all forms of physical punishment should be discouraged. More positive and constructive forms of discipline should be encouraged. Numerous organizations such as the Canadian Association of Social Workers and the Canadian Psychological Association have implemented policies against the use and promotion of physical punishment. This document follows their lead.

4. The Effects of Witnessing Violence

Although parents often believe that they have sheltered their children from the violence in their relationships, between 80% ad 90% of children in homes characterized by partner violence are aware of and are affected by the violence (Fitzgerald, 1999; Wolak & Finkelhor, 1998). In Canada about 461,000 children witnessed violence in their homes and in about 70% of the cases where children witnessed partner violence, it was the mother who was assaulted (Dauvergne & Johnson, 2001). Exposure to family violence is the most prevalent form emotional abuse of children in Canada (Trocme et al., 2001).

Children younger than five years old are most likely to be in the home when the violence occurs and to be exposed to more incidents of violence than older children due to their level of dependence and not being in school (Fantuzzo & Mohr, 1999). Approximately 40% of children from violent homes present with behavioural problems within the clinical range (Harold & Howarth, 2004). The effects of witnessing violence are both direct and indirect. Direct effects result from observing the violence or being injured during altercations. These experiences have been linked to fears, anxieties, excessive clinginess or neediness, withdrawal and emotional detachment, depression, suicidal behaviour, insomnia, bedwetting, post traumatic stress disorder, anger, and aggression in children (Fantuzzo & Mohr, 1999; Johnson & Roseby, 1997; Koenin, Moffit, Caspi, Taylor, & Purcell, 2003; Osofsky, 1999; Wolak & Finkelhor, 1998). Cognitive delays, attention problems (Marks, et al., 2001; Sox, 2004), and problems related to social competence such as difficulties resolving conflicts and empathy development have been found in children witnessing violence (Edelson, 1999; Fantuzzo et al., 1991; Jaffe et al, 1990; Marks et al., 2001; McCloskey & Lichter, 2003; McCloskey & Stuweg, 2000; Rosenberg & Rossman, 1990; Sox, 2004). Because parents are powerful role models children may learn to use aggression to resolve problems and conflicts, thus imitating what they have seen in their own interactions with others (Grych & Fincham, 1990).

Indirect effects result from changes in parenting practices and parental stress effects related to partner violence. Consistency in parenting practices, rules, and discipline is reduced in violent homes (Holden & Ritchie, 1991; Jouriles, Spiller, Stephens, McDonald, & Swank, 2000; Onyskiw & Hayduk, 2001; Roseby & Johnson, 1997; Wolak & Finkelhor, 1998). These parents tend to have fewer interactions with their children and are less emotionally stable than parents from non-violent homes. Research has found an association between maternal stress due to partner violence and emotional and behavioural problems in their children (Hughes & Luke, 1998). Depression is common in women who are abused. Children witness the emotional withdrawal, sadness, irritability, hopelessness, guilt and other negative emotions of depressed parents (Wolak & Finkelhor, 1998). Behavioural problems have also been linked to the irritability, anger and lack of child care evidenced in fathers who behave abusively.

Because parents involved in abusive partner relationships may not be emotionally available to their children and may be unresponsive to their needs or at least inconsistently responsive (Hilton, 1992; Holden & Ritchie, 1991), children are at risk for receiving less affection, attention, and support (Osofsky & Fenichel, 1994; Wolak & Finkelhor, 1998). This can impair the development of trust and attachment within these families (Johnson & Roseby, 1997). It is believed that attachment in childhood establishes a pattern for attachment in adulthood and therefore children who have insecure attachments in childhood will replay those attachments in their adult relationships. Violence is modeled as a viable way of solving conflicts, dealing with anger, and even of showing love (Cappel & Heiner, 1990; Doumas, Margolin & John, 1994; Straus, Gelles & Steinmetz, 1981). Children who have witnessed violence have been found to use and experience more violence in their relationships as adults.

Research has examined factors in children's lives that are related to the impact of witnessing violence in the home. The effects are to some degree dependent on the age and gender of the child witnessing the abuse, and the nature and severity of the violence. Further, the presence of other stressors and protective factors in the child's life can either compound or ameliorate the impact of witnessing violence.

A) Age

i) Infants (birth to 2 years of age)

Infants are sensitive to their parent's emotions and to the emotional atmosphere in the home. They will often cry or become distressed as an expression of their discomfort or fear at the tension and noise in the home. This distress may be left unaddressed as the parents are focused on their own emotions and the violent or abusive situation. As a result, babies from violent homes often present with health problems, are underweight, have sleep and eating problems, cry a lot, and don't engage with others. (Osofsky, 1999; Wolak & Finkelhor, 1998). Establishing trust and security with parents may be difficult in these situations.

ii) Toddlers and Preschool Children (2 to 5 years of age)

Toddlers will typically look to their parents or guardians for comfort and security when confronted with uncertain, frightening or confusing events. If parents are physically and emotionally unavailable, the child's development of trust will be impaired, which will adversely affect their exploratory behaviour and independence (Osofsky, 1999). Further, some young children may feel responsible for the unhappiness and anger of their parents and may have conflicted feelings about the parent who has behaved violently, whom they both love and fear. Huetteman, (2005) reports that although preschoolers from abusive homes had positive feelings about their mothers, they had both positive and negative feelings about their fathers. The behaviours reported in toddlers and preschoolers who witness violence between their parents have included being aggressive and demanding, being overly talkative and physically active, being overly dependent, clingy and whiny, regressing to infant behaviours such as sucking their thumb and bed wetting, and a number of physical complaints such as stomach aches and head aches (Wolak & Finkelhor, 1998). There have been some indications that preschool children are more negatively affected by witnessing violence as compared to school-age children (Guille, 2004).

iii) School Age Children (6 to 12 years of age)

Because school age children see their parents as role models, they often have a difficult time coming to terms with their feelings about parents who are violent. Children of this age understand events in concrete terms and will often focus on the specific details of the event. Many will also identify with their same sex parent, leading to confused emotions (Cunningham & Baker, 2003). Ambivalent feelings of both admiration and fear for the violent parent and sympathy and anger toward the victimized parent are not uncommon (Morgentaler, 2000; Sternberg et al, 1994). A variety of behavioural effects have been identified in these children. Like preschoolers, they may be aggressive, but it may be more noticeable once they begin school. Many have interpersonal problems either due to their aggression or because they isolate themselves to avoid having others find out about the violence in their home (Osofsky, 1999; Wolak & Finkelhor, 1998). School related problems such as difficulty in doing academic work, concentration problems, and lower scores on verbal, motor, and cognitive skills have been reported (Fantuzzo & Mohr, 1999). Some are very fearful and have anxieties related to fear of abandonment, fear of being killed or of killing someone, and fear of their own anger or of others anger. Some feel guilt and self blame for the conflict between their parents. Many will try to intervene and/or protect their mother and become injured in the process. Children of this age may take on a parenting role, caring for younger siblings when their parents are not able or willing to do so. They may also become caregivers for their parents who are depressed or otherwise lack the inclination or capacity to care for themselves. This role reversal is often referred to as *parentification.* Often these children will have developed a sense of insecurity and distrust of their environment as they view the world as unpredictable and dangerous (McAlister Groves, 1999; Wolak & Finkelhor, 1998). In terms of emotional effects, sadness, depression, low self esteem, and emotional neediness are common.

Eating disorders and substance abuse are ways that these children sometimes cope with the violence in their homes (Osofsky, 1999; Wolak & Finkelhor, 1998).

iv) Adolescents (13 years and older)

Adolescents often have been living with their parents' violence for years and they begin to feel less responsible for the violence at this age. However, even when they realize that this is their parents problem, they still feel neglected, angry, hurt, and confused about their feelings towards their parents. Many times they will turn to peers or other adults for support and affection. Some may become sexually or romantically involved early to obtain the affection they do not get at home, thus, early pregnancy and marriage is a concern. Violent behaviour towards others, dating violence, delinquency and criminal activity may occur. Coping through substance use and risk taking behaviours is common. Depression and suicide are also frequent. Some will run away from home to escape the violence (Carlson, 2000; Wolak & Finkelhor, 1998).

B) Gender

Many studies have suggested that boys manifest more externalizing behaviours such as aggression and conduct problems while girls present with more internalizing behaviours such as depression and withdrawal (Jaffe, Hurley & Wolfe, 1990). On the other hand, other studies have not found this differentiation (Gleason, 1995; Wolak & Finkelhor, 1998). Some research has found that boys have more problems with peer relationships, independence, self control and overall competence (Edelson, 1999). Further, Carlson (1991) reported that boys from violent homes were more likely to have attitudes approving of violence than were girls. Despite potential gender differences, practitioners should expect internalizing and externalizing behaviours in both boys and girls and deal with these behaviours as they present themselves.

C) Severity of the Violence

Research indicates that the longer the duration, the greater the frequency, the more harm done to the victim, the more overt the conflict, and the closer the child's proximity to the violence, the greater the impact of witnessing the violence and the more likely symptoms will appear (Harold & Howarth, 2004; Jouriles, McDonald, Norwood, Ware, Spiller & Swank, 1998). For example, Grethel (2005) found that children exposed to more severe forms of violence presented with more aggressive behaviour, attention problems, anxiety, depression, and dissociative symptoms. In cases of extremely severe abuse where the child fears for theirs or their parents life, symptoms of post traumatic stress disorder (PTSD) have been reported (McAlister Grove, 1999; O'Keefe, 1994; Wolak & Finkelhor, 1998). Generally, the longer the period since exposure to the violence, the fewer effects are manifested in children (Edelson, 1999).

D) Presence of Other Stressors

Children who witness violence between parents are affected by other stressors. There is often frequent marital conflict and verbal and emotional abuse in the home, as partner violence tends not to occur in isolation of other forms of abuse. Further, these children are at greater risk for experiencing abuse themselves, either unintentionally when they try to intervene in violent episodes or intentional when one or both parents become abusive to their children. Studies have shown that children who witness violence are at greater risk for experiencing violence themselves (Dube, Anda, Felitti, Edwards, & Williams, 2002; Wolak & Finkelhor, 1998). Children who both witness and experience violence in the home are more likely to have dissociative symptoms than those who witness but do not experience violence (Grethel, 2005), and adolescents who experience both of these forms of violence are at greater risk for attempted suicide and aggressive behaviour (Yexley, Borowsky, & Ireland, 2002).

Some children who witness violence live in communities where violence is common and some live under conditions of poverty. Families characterized by partner violence are also at higher risk for substance abuse problems, separation and divorce, and mental health issues (Dube et al., 2002; Fergusson & Horwood, 1998), all which exacerbate the effects of family violence (Rossman, 2000). Even when the violence is addressed, these children may experience added stress. Leaving home and living in a shelter can generate negative or problematic behaviours, as can any involvement in the justice system for themselves or their mothers. For example, custody battles have been associated with fear and stress for these children (Goodman & Rosenberg, 1987; Wolak & Finkelhor, 1998). Grethel (2005) found that the presence of psychosocial stressors in the lives of children witnessing violence were related to somatic complaints, social difficulties, attention deficits, and dissociative symptoms.

E) Protective Factors

There are a number of elements in the child's life that can act as buffers to the stress and trauma of witnessing violence. The child's own personality and temperament can promote resiliency. Optimism and not taking on blame for the violence are two such characteristics (McAlister Groves, 1999). Support and care from a strong and healthy relationship with a loving adult that they can talk to about the violence has been found to help children cope with their experiences (Wills, Blechman, & McNamara, 1996). In addition, research has indicated that children's perceptions of the violence and conflict between their parents will affect the impact of the violence witnessed (Harold & Howarth, 2004; Harold, Pryor & Reynolds, 2001). Taking responsibility for intervening and ending the violence, viewing the conflict as personally threatening and indicative of how their parents will treat them, and feeling unable to cope, all negatively impact on emotional security which then leads to increased psychological distress (Harold, Fincham, Osborne, & Conger, 1997; Harold, Shelton, Goeke-Morey, & Cummings, 2004). Children who do not hold these perceptions are more resilient and are less likely to develop severe psychological distress. This indicates that intervention approaches

need to help children understand and cope in a more adaptive manner to their experiences of witnessed violence.

II: Service Providers

Screening potential employees who will be working with children and their families is an important part of the process of providing effective services. Potential children's service providers should be asked about their views on parenting and discipline, as they will be imparting information on these issues to parents. Asking questions about their experiences growing up and their own issues about childhood and family violence will be important in determining what their personal issues and biases may be and to what degree they have dealt with them. It is important that personal issues not negatively influence intervention methods. The screening for these issues and the qualities detailed below may be guided by the checklist found in Appendix A. Screening will need to include a criminal record and child abuse registry check. This section looks at qualities and characteristics of service providers that would benefit their work with children and offers suggestions regarding training and supervision of staff.

1. Qualities and Characteristics

Below are a number of service provider qualities that would help provide more effective services for children affected by family violence. Appendix A presents a checklist of qualities and qualifications that can be used in screening potential employees who would be working with children. The qualities detailed below can be found in that checklist.

A) A Genuine Liking for Children

Because service providers will have contact with children on a daily basis, it is important that they genuinely like children. This will make them more satisfied with their jobs and thus more effective in their work. Individuals who are happy in their employment are enthusiastic about seeking new and better ways of doing their job. Further, children are very perceptive and they will pick up any dislike or discomfort on the part of the service provider. This knowledge will be detrimental to the building of trust and rapport between the service provider and the children they serve.

B) Recognize the Rights of Children

Because adults make so many decisions for children, it is sometimes easy to overlook their rights as individuals. Some service providers will be asked to advocate for children and to represent children's best interests. It is therefore important that they view children as persons with the same rights as all persons and recognize that these rights must be respected and protected.

C) Flexibility

Individuals who work with children have to be comfortable with ambiguity, chaos and non-structured behaviour and intervention. Children are in the process of learning self regulation and therefore, service providers should not expect them to manifest the controlled behaviour evidenced in adults. Rather, they should see themselves as models and socializing agents for the development of self regulated behaviour in the children. Flexibility will also play a role in applying different methods of intervention tailored to each child's needs, development and comfort level. This flexibility comes with an understanding of child development and a genuine liking for children.

D) Sense of Play

Service providers should feel comfortable interacting with the children on their level. They need to have a good sense of humour, a sense of fun, and a willingness to play. Children spend a lot of time in play and process a lot of their experiences through their play. They will often talk about their feelings, perceptions, and experiences while they are playing. Service providers need to be able to engage the children in play and to become part of the play in order to fully utilize these opportunities for understanding the children's issues and for effective intervention. Suggested methods of assisting children to cope with their experiences may best be presented during play.

E) Awareness of the Nature and Effects of Family Violence

Because service providers will be helping children heal from experiences of family violence and helping parents assist their children cope with these experiences, it is important that they have extensive knowledge of family violence. This knowledge should include an understanding of the dynamics of family violence, the different types of partner violence, the effects of violence on children and parents, and what makes people behave violently or abusively. Service providers need to know and support the process whereby children heal from experiences with family violence. Supporting this process consists in part of a familiarity with different approaches to intervention and an appreciation for the benefits of a family systems approach. Knowledge and willingness to utilize different techniques depending on the child's age, temperament, and presenting effects is essential to individualized and effective intervention.

Part of the awareness of the effects of violence is a knowledge of the myths about these effects. Among the most common of these myths are:

a. Children are not aware of the violence in the home if the parents do not behave violently with each other in front of them. Research has demonstrated that 80% to 90% of children in homes characterized by partner violence are aware of and affected by the violence (Fitzgerald, 1999; Wolak & Finkelhor, 1998).

b. Children do not think about or commit suicide. Although adolescence are more prone to suicide, young children also suffer from depression and suicide ideology. In Canada suicide is the second leading cause of death for children and youth ages 10 to 24 (Canadian Mental Association, 2001), with males more often committing suicide than females (Statistics Canada, 2005). Children exposed to violence in the home are particularly at risk (McWhirter, McWhirter, McWhirter, & McWhirter, 2004).
c. Corporal punishment of children has no negative effects. The literature indicates that corporal punishment can easily lead to abuse and that physical discipline negatively effects children's sense of self and transmits messages about the acceptability of the use of violence (Trocme, et al., 2001;Voices for Children, 2003).

Effective intervention is predicated on non-belief and non-support of these myths.

F) Knowledge of Child Development

A knowledge of child development will help service providers understand children's behavioural and cognitive capacities at different stages of development. This will help them know how children process information and at what level information should be presented to children of different ages. This knowledge can also be imparted to parents as service providers will be helping them both understand and help their children through the healing process. This knowledge can come from formal education on child development and/or through extensive experience with children of different ages. There are many sources of information on child development that can be used as the basis for knowledge and as refreshers (for example Berk, 2006).

Part of knowing about children's development involves an understanding of their basic needs such as for food and comfort and how meeting these is necessary before more psychological and social forms of intervention can take place. Children who are hungry, frightened, or feeling isolated will not be able to relax enough to open up to the service provider or concentrate on learning ways to cope with their experiences. Service providers should always make food available to the children. Further, sometimes eating together builds closeness and creates a situation for sharing of information. Children may also need to be reassured that they are not alone and that their wishes will be respected. For children whose rights have been violated, the knowledge that they are now being respected may go a long way to building trust with a service provider. Providing comfort is important but should be based on what is comforting to the child. The service provider should always take their cue from the child.

A knowledge of good parenting skills will be beneficial. In programs taking a family systems approach, parents will be part of the treatment plan. The service provider will likely need to teach parenting skills such as safe and effective disciplinary methods, helping the child with new ideas and concepts, and ways of coping with change. Providing opportunities to practice these skills will increase the likelihood of their successful application. In some cases service providers will have to teach more of these

skills than in others. Determining what skills will be taught will be part of the assessment process.

G) Being a Role Model

The service provider should realize that, as an adult that children interact with on a regular basis, they will be serving as a role model. Appropriate behaviour towards others, appropriate language, and appropriate perspectives of the violence and how to address it should be modeled to the children and to their parents. Within the family systems approach, service providers will be helping parents understand how the abuse has affected their children and how they can help their children's healing process. Therefore, service providers must also realize that they will be serving as role models for parents. Consciousness of this role is important to remaining vigilant about the attitudes and beliefs portrayed through their behaviour. Hypocritical behaviour will not be effective in intervention with children and families affected by violence.

H) Experience Working in Crisis Situations

Because service providers will be working with families in crisis, it is important that they be trained to deal with crises. The crises they encounter will be difficult to predict and therefore they should have an effective approach to dealing with crises in general. The capacity to remain calm and focused will reduce the panicked nature of the crisis. A calm and efficient approach will help the family build trust in the service provider and see her as a safe person who can help them in times of crisis. The child will be more likely to see a calm, confident service provider as someone they can depend on when situations are difficult and someone who will not be shocked or upset by what they might disclose. Training in Emergency First Aid and CPR would also be beneficial in helping individuals deal with emergency medical situations that may occur.

I) Good Counselling Skills

There are a number of counselling skills that are necessary for individuals working with children affected by violence. Among these are:

- Be a good listener. Listen carefully to what children are saying, especially since they will sometimes reveal information in indirect ways, as in play. Engage in active listening and ask questions that will clarify children's statements.
- Be patient. It takes time to build trust with children, especially with those whose trust has been violated. A good counsellor will wait for the child to talk about their experiences rather than force the issue. This places control back in the hands of the child, a control they may have felt was often taken away from them. Researchers report that children have indicated that they prefer when they can tell their story at a pace that is set by them (Mullender, Hague, Imam, Kelly, Malos, & Regan, 2002).

- Put the children's needs first. The point of counselling is to serve the children and therefore their needs have to take precedence. Even when dealing with the children's parents, it is the children's needs that have to be considered first.
- Be objective. Do not take children's anger and hesitancy to trust personally. They are having a natural response to their experiences with family violence and this response is unrelated to the service provider. The service provider must work to objectively understand children's responses without reacting at a personal level.
- Be aware of and maintain boundaries. Young children are in the process of learning about boundaries and may cross them at times. Further, sometimes children who have been exposed to violence have problems with boundaries. Counsellors need to be aware of these issues and not react negatively to boundary violations by children. They must also be cautious not to cross boundaries themselves, either children's boundaries or parents' boundaries. Counsellors who do not have a clear sense of their boundaries and who cross those of others are less effective in helping individuals heal from violent experiences and risk re-exposing individuals to the boundary violations they experienced through violence and abuse.
- Maintain confidentiality of information at all times. This is an essential component of any form of counselling.
- Be aware of personal biases and do not let them affect the interventions used. Everyone has personal beliefs and biases, but as counsellors these should not be allowed to affect their behaviour with children and their families. Displays of biases against parents and their behaviour may be particularly detrimental to building rapport with the child and with the family. Some service providers use their own support systems and counsellors to deal with their own personal issues, so these do not affect their intervention work.
- Be able to talk openly about sensitive issues. Service providers will be hearing children's stories of witnessing and sometimes experiencing violence and abuse within the home. Research has revealed that children want to be able to tell their stories and to talk about their fears (Mullender, et al., 2002). Some children are relieved at finally being able to talk about the violence and doing so may help them gain a sense of control over the experience (Pynoos & Eth, 1986). Service providers may also hear about suicidal thoughts and self blame for the violence. The Canadian Mental Health Association (2001) states that in responding to children's suicide attempts or ideation "it is more effective to express a willingness to talk and to be supportive, no matter what may be happening in the child's life." Service providers must be prepared to hear this information and to respond appropriately, as children will carefully monitor their reactions to what they reveal and any further disclosures will be affected by these initial responses. A level of comfort with asking sensitive questions is a necessary part of counselling. Training can be important in building this comfort in dealing with sensitive issues.

J) Self Reflection and Self Awareness

Within the counselling relationship the focus must be on the children and their families. Thus, service providers need to be aware of their own issues around family violence and have dealt with those issues to the degree that they do not interfere in the counselling situation. Part of this awareness includes recognizing when their personal issues have been triggered and responding in a way that is most respectful and helpful to the family. This may include consulting with their supervisor as to the best course of action or to address some of these personal issues.

K) Knowledge of Community Resources

Working with children and their families will often require making contact with collateral agencies for referrals or for the purposes of joint service. Further, because families will be presenting with a variety of issues and problems, different types of resources will be required. For these reasons, it is important that service providers have information about the community resources available for the children and families they serve.

L) Good Organizational Skills

In addition to counselling and treatment, service provision also requires a great deal of documentation and record keeping. Client files must be maintained and kept up to date and records of referrals and collateral agency contacts and follow-ups on behalf of the client are often kept. Documentation of client progress, dietary needs, medical conditions and medication need to recorded. Legal documents, consent forms, correspondence also must be included in client files. This significant amount of file maintenance will benefit from well developed organizational skills.

M) Self Care

Because individuals will be dealing with traumatic experiences of children on a daily basis, they must ensure their own self care. This will involve accessing their own support systems, debriefing with colleagues, going for counseling themselves, and maintaining a healthy emotional distance from the children and families they serve. It will also entail remaining physically healthy. Eating healthy, getting sufficient sleep, and getting regular exercise are all part of a healthy life style that will improve physical and mental health. A healthy individual is in a much better position to be helpful to others.

2. Training and Supervision

Regular supervision and/or consultation with a supervisor is recommended for service providers. This will give individuals an opportunity to debrief, obtain guidance with

difficult cases or issues, and ensure that they are meeting the requirements of their positions. Following ethical guidelines will also be part of the job requirements. Supervisors will not only oversee ethical behaviour but will also offer advice in cases of difficult ethical dilemmas. Please see the Recommended Resources section highlighting codes of ethics for several human-service related professions in Canada.

Ongoing training and professional development will provide individuals with a broader perspective and knowledge base which they can then apply in their intervention methods. It will ensure essential knowledge such as child development, family violence and theoretical approaches and intervention methods. A degree in a field such as psychology or social work will provide information about child development and different methods of intervention, however, there are specialized certificates and courses that can also teach this information. There are a number of training options available and some employees may require that these be done prior to hiring, while others may suggest that these options be taken advantage of after hiring. These options may also be considered as professional development opportunities. Below are some of the training options available in Manitoba.

1. ASIST – This program, available though Living Works, trains service providers to deal with suicidal children.

2. Play Therapy Certification Program– Available through the Canadian Association of Child Play Therapists (CACPT), Manitoba Chapter: www.cacpt.com/about-provincial.htm.

3. Emergency First Aid Training

4. CPR Training

5. Triple P – The Positive Parenting Program (www1.triplep.net) offers broad based training for parenting issues at five levels, with each level taking about three training days. Originating out of Queensland University, the Healthy Child Initiative of the Manitoba Provincial Government is making it available for free to all service providers working with families.

III: Frameworks of Intervention

1. Theoretical Contributions

Programming with children requires consideration of various theoretical contributions. This guide highlights four frameworks which provide a good basis from which to work in child witness situations. These frameworks are not intended to provide a single "solution" to programming but can be integrated into programming as is appropriate for each child and each situation. They can also be incorporated into personal approaches and philosophies for working with children and families. Theoretical frameworks underlie different intervention models. These models will be presented in a later sections.

A) Family Based Approaches

Families are the primary socializing agent for children (Margolin, 2005). Because a child's world is embedded within the context of their family, it is strongly encouraged that work with children should also include work with the family. Helping family members to recognize and understand how interactions within the family system affect the child is an important aspect of the therapeutic treatment (Geldard & Geldard, 2002). It is particularly important when the issues being addressed include domestic violence.

While some programs do endorse "child-only" intervention, many support programming that involves parents, either through intervening with the family system, or through parallel but separate services for the parent(s) (Rivett, Howarth & Harold, 2006). Both nurturing the attachment between children and their parents as well as the entire family system have been identified as important aspects to children's development in situations of marital conflict (Owen and Cox, 1997). The "inherent paradox that the family, as the primary source of protection for the child, also is the source of violence" (Margolin, 2005, p.74) is central to address when working with children who have witnessed domestic violence. It is necessary to find ways for the child to process the violence and re-establish a sense of safety as part of the family and this can only be done with the involvement of the child's family system. Among the reasons it is advisable for parents to be involved in programming are the following:

1) Parents who have been involved in domestic violence will be experiencing various effects from this experience. Studies show that these parents, as well as the whole family system, are drained of their ability to provide supports. They will likely benefit personally from counselling which in turn will help the child and the family system, by, among other things, becoming more emotionally available to their children (Margolin, 2005; Rivett et al, 2006). This can include both counselling services as well as parenting services.

2) It is advisable for custodial parents, often mothers, to be involved in programming in some way because if the child is learning and growing through the therapy and the rest of

the family is not, frictions and misunderstandings may arise. For example, a child may learn that a behaviour such as screaming, which they once considered normal, in fact constitutes abusive behaviour. On the other hand, the mother may not see this type of behaviour as abusive and thus tensions between mother and child may result (Peled & Davis, 1995). Such tensions could be detrimental to the mother/child relationship and thus to the child's recovery. Opportunities to change the mother's perspective can assist the child's learning and the family system.

B) Attachment Theory

Attachment Theory was introduced by John Bowlby who "theorized that children had a biological predisposition to form attachment relationships and that these begin in mother-infant interactions" (Ross, 2004, p.30). Bowlby proposed that children build mental representations or 'internal working modes' of their own worthiness from experiences and perceptions of caregiver's availability, and their ability and willingness to provide care and protection" (Bacon and Richardson, 2001, p.378). Bowlby believed that the child's behaviours later in life, including their ability to be resilient to stressful situations, would depend on the way in which they had attached to the mother (Geldard & Geldard, 2002; Ross, 2004). Attachment styles develop in response to the quality of the relationships with the primary caregiver and are either secure or insecure in nature. Secure attachment leads to well adjusted children, while insecure attachment could mean social and emotional maladjustment in children. How well a child can separate and develop as an individual, and form healthy relationships with others is influenced by the mother-child attachment. While attachment theory was originally developed based on a child's attachment with a mother, a child's attachment to their parents including fathers, is important in their development.

Bacon and Richardson (2001) state that "The overall conclusion of the available research is that any intergenerational 'cycle' reproduces patterns of insecure attachment" (p.7). This is particularly true in families where domestic violence is present. The significance of parenting and attachment in the mother/child relationship in mediating the impact of the martial conflict on the child has been documented (Levendosky et al, 2003; Ross, 2004; Bacon and Richardson, 2001). This relationship appears to be especially important with preschool children, ages three to five (Levendosky et al, 2003). The mediating role of attachment can be improved by developing ways to forge a positive bond between the child and the non-violent caregiver (Groves, 2006). The non-abusive parent's capacity to protect the child and to think reflectively about the violence is critical for the child's long-term recovery, as it can assist the child in dealing with and integrating the impact of the family violence. A child's anxieties and fears can be greatly reduced when parents are able to provide support appropriate to the trauma the child has experienced (McIntosh, 2002). With these findings in mind, it becomes clear that it is important to provide services to both mother and child in order to improve their relationship and reduce the likelihood of long term symptomatology (Ross, 2004).

C) An Aboriginal Perspective

While there is not one specific Aboriginal perspective on family violence and healing, there are some common threads throughout Aboriginal approaches. These include Aboriginal identity, holistic world view and values (Baskin, 2003). Aboriginal identity is interwoven with cultural values that include a focus on cooperation, an emphasis on giving, a community focus, and respect for Elders and children (Baskin, 2003). Children have traditionally been regarded as gifts from the Creator and it is the role of all adults within the community to ensure their well-being (Dumont-Smith, 1995). However, current statistics demonstrate that Aboriginal children are at great risk of living in poverty and of witnessing and experiencing violence (Dumont-Smith, 1995). While the dominant western approach assumes a homogeneous perspective of family violence, Aboriginal perspectives place family violence in indigenous communities within the "historical context of colonization, oppression, dispossession, disempowerment, poverty, and cultural, social and geographic dislocation as these affect individuals, families and entire communities" (Cheers, Binell, Coleman, Gentle, Miller, Taylor & Weetra, 2006, p.2). In working with families who have Aboriginal connections it is critical to consider these multi-systemic issues which likely impact their daily life and health, in addition to the family violence experienced.

An Aboriginal concept of health is holistic in its approach. That is, the four elements of physical, mental, emotional, and spiritual health are interconnected and must be balanced for optimum health (Dumont-Smith, 1995; Baskin, 2003). Interconnectedness of peoples lives is central to this: "to be in good health, one must live in harmony with oneself, family, community and all living and even nonliving things of nature" (Dumont-Smith, 1995, p.281). Aboriginal perspectives understand that conflicts can only be resolved through restoring health through balance and harmony of the four aspects of health in both the person who has experienced the violence and the person who has behaved violently (Dumont-Smith, 1995).

There are many traditional methods which can be incorporated into the healing process for children who have witnessed domestic violence. Prayers to the Creator, spiritual ceremonies, use of traditional medicines, and healing circles are some of the methods used by traditional healers. Clients' desire to incorporate these healing methods into their treatment should be respected. It is advised that an Elder be involved and/or consulted in these cases, particularly when the service provider or agency is not connected with Aboriginal heritage. Education about Aboriginal culture and traditions as a way of building positive self-esteem for Aboriginal children can be especially beneficial (Dumont-Smith, 1995). Restorative circles have been used in some circumstances to confront a person who has used violence. Depending on the family's cultural experience or wishes, some families may want an opportunity incorporate this approach into their healing. Again, working with an Elder is recommended.

In working with clients within an Aboriginal perspective, it is critical to keep in mind that the relationship focus is very important.

> It is important for a First Nations person to have a relationship with someone before he or she develops trust in that person and is able to confide in him or her. A First Nations person will not ask intrusive questions of others as so often happens within mainstream helping professions. They see that a relationship needs to be established before a dialogue can begin. There is an emphasis on taking the necessary time to develop relationships, which conflicts with the fast, task-oriented focus of dominant society. (Baskin, 2003, p.69).

D) Feminist Perspective

The feminist perspective on family violence has gone through considerable evolution throughout the past 30 years. It has always been a critical voice in challenging assumptions on systems and gender. However, current discourse argues that while it has at times been narrow in its articulation of causes for family violence, it offers an important perspective into this topic, primarily because it is most often women who are at the receiving end of family violence.

Mainstream feminism has placed "male-female relations at the center of their analysis and views inequality between men and women as a key factor in violence" (Kurz, 1989, p.490). It argues that socially structured and culturally approved gender inequality is causative in understanding domestic violence. Feminist approaches contextualize domestic violence historically as institutional condoning of husbands' use of physical violence to control their wives (Sokoloff, 2004; Kurz, 1989). Within heterosexual couples, men use violence to control female partners. In North America and other cultures, women have less power and fewer resources than men, who dominate all aspects of private and public life. While women do behave abusively, women who engage in acts of violence within intimate relationships primarily do so in self-defence. Within same-sex couples women can behave abusively as well and feminist theories have continued to focus on issues of dominance and control as part of that abusive behaviour. Feminists attest that within western culture there is social acceptance of violence, meaning that while domestic violence may be transmitted through familial patterns there are also wider forms of socialization through which this behaviour is taught as acceptable. Feminism states that a significant outcome of male dominance is economic dependence for women. This leaves them with few alternatives when their partnership with a man becomes violent. A feminist perspective also takes into consideration a mother's concern that her children may be taken from her if the authorities deem she is unable to protect her child (Kurz, 1989).

This mainstream feminist theory outlined above has primarily come out of a tradition of white, heterosexual, middle class women. This approach now recognizes the need for cultural considerations, as cultures vary in their understandings of male/female relations, norms of violence, and family systems. In recent years this theory has broadened to incorporate the intersecting factors of oppression which are experienced by women in addition to their gender (Sokoloff, 2004). Many women live within intersecting margins, including race, ethnicity, class, sexual orientation, immigrant and disability status. These

overlapping sources of oppression are now perceived as intensifying the experience of oppression (Krumer-Nevo, 2005; Sokoloff, 2004; Mullaly, 2002).

2. Contextual Issues

A) Connecting With Other Agencies

The development of effective treatment for family violence prevention is still very new. Studies are indicating that factors other than treatment, such as marital status, residential stability, and employment are either as important as or more important than treatment (Stover, 2005). Family issues such as poverty, schooling, and housing need to be addressed through the involvement of appropriate agencies (Shepard & Pence, 1999). These are factors which influence the child's life, but over which they have no control. Working with the parents to address these issues will also contribute to the child's wellness and treatment: "The more people who are supportively involved and committed to bringing about positive change, the higher the likelihood of success" (Sharry, 2004, p.12). In their 2003 publication *Children who live with violence: Best evidence to inform better practice*, Cunningham and Baker suggest that the problem of domestic violence needs to be addressed at a community level and across professions to provide a holistic intervention.

Because children spend a significant amount of time in school or day care, it is important to make connections with these agencies. Treatment that includes consultation with teachers or child care providers allows for the development of consistent strategies for the classroom or day-care setting. This also helps strengthen these emotional supports for the child. The classroom offers children who live with family violence a space that is generally safe, predictable and comfortable. There are many opportunities for teachers to identify violence in children's lives. Because teachers are often respected and idolized by their students (particularly younger children), it is a good opportunity to develop a warm and secure relationship built on encouraging children to share their worries and fears (Groves, 2002).

When including a wider system in programming, caution should be used to ensure that the child's voice is not lost between professional and parental concerns. This can be done by developing ways to ensure a more "child-focused" practice (Sharry, 2004). The child and their concerns and issues should be the focal point of all systems involved in treatment.

B) Cultural Issues

Creating culturally-sensitive practice involves awareness as well as action. It is helpful for service providers to understand the ideologies of how culture affects different situations and may allow violence to continue. Further, cultural sensitivity includes recognition of various power structures that effect domestic violence (Cheers, Binell,

Coleman, Gentle, Miller, Taylor & Weetra, 2006). Service providers need to be aware of sociocultural issues, stereotypes, and prejudices that may contribute to the clients presenting problems and the service providers perceptions of problems (Sharry, 2004). An awareness of and comfort with discussing the effects of oppression on daily lives of minority individuals is important (Silvern, Karl, & Landis, 1995). Appreciation for both challenges *and* benefits of different cultures is an asset in working with any person. Service providers should not make assumptions regarding culture, including service providers who are perceived to share a similar background with the client, as differences in sub-cultural backgrounds may exist (Sharry, 2004). It is advised that client's culture be learned *from the client*, their family, other service providers or consultants that are more familiar with the culture. This may curb misunderstandings and assumptions in assessment and treatment and will also help them to understand how a parent's country-of-origin or cultural background may influence their parenting styles (Sharry, 2004).

An individual's personal culture is influenced by their ethnic background as well as any sub-cultures they are part of, including socio-economic, gay/lesbian, and disabilities (Sharry, 2004). For children from minority groups, witnessing interparental violence may compound the sense of personal danger and helplessness they already experience from the ostracism, marginalization, threats, abuse and violence related to their minority status. This intensified sense of vulnerability and the subsequent need for self protection and defensiveness may hinder the process of disclosure (Silvern, Karl, & Landis, 1995). Ensuring confidentiality may help clients sharing their experiences with a service provider. Be aware that while service providers who share cultural connections with clients may be beneficial in developing rapport with clients, there may be concerns on the part of adult clients that confidentiality will not be maintained within cultural communities (Proulx, Laurie & Fraelich, 2005).

There are a number of steps service providers can take when working toward creating a culturally-sensitive practice. Promoting a sense of safety and ease for clients can include tailoring the physical space to a child's/ family's particular needs, value systems, and treatment that fits with their cultural experience. Allowing for cultural practices such as smudging when they are important to the client will demonstrate respect for the individual. Further, when working with group programs, service providers must have a heightened awareness of cultural differences as group members may have diverse backgrounds. Connecting clients to cultural services and program in the community is yet another way of providing culturally sensitive service and encouraging the therapeutic process (Silvern, Karl, & Landis, 1995). Several suggestions for enhancing staff awareness of cultural issues include: having and supporting staff from diverse backgrounds; liaising with community agencies that can provide workshops and/or consultations on cultural issues; and encouraging staff to reflect on their own personal identity, cultural issues, personal approaches, and biases that may impact on their work (Sharry, 2004; Silvern, Karl, & Landis, 1995).

IV: Assessment and Intake Issues

1. Contextual Issues

Gathering as much information about the family context as possible will help the service provider to work with the family in developing appropriate interventions for the family system and individual members within the family. It is important to develop a full picture of the family, including: emergency contacts, educational background of family members, household composition, school attendance, service needs in the family members words, primary physician, history of involvement with justice system, if the family going through a divorce and if so what is the level of conflict, role of religious practices in family life, and ethnic and cultural influences. If possible, it can be helpful to obtain information concerning violence exposure immediately following the incident as this is when the experience is fresh and "less vulnerable to retrospective distortion" (Drotar et al,, 2003, p189). See Appendix B for a checklist of things to consider regarding a family's context. Discussing confidentiality in the first interactions with a family may be helpful in gathering information on their situation as it may begin building a trusting relationship.

Children's access to an adult figure who can support them in their experience of trauma and promote effective coping may reduce the need for formal mental health intervention. The complex effects of domestic violence are often greatly moderated if the non-abusive parent is emotionally available to the child (Groves, 1999). Thus, the presence of support from the non-abusive parent and/or from other adults in the child's life needs to be assessed.

2. Issues Related to the Experience of Violence

Numerous studies demonstrate high levels of co-occurrence between witnessing spousal violence and child abuse and it is *absolutely critical* for service providers to have an awareness of this strong co-relation (Carter, Weithorn & Behrman, 1999; Dong, Anda, Felitti, Dube, Williamson, Thomson, Loo & Giles, 2004; Groves; Kurz, 1989; Salcido Carter, Weithorn, & Behrman, 1999; Saunders, 2003). Because of this co-occurrence, those working with children who have witnessed violence must be aware of the strong likelihood that additional forms of domestic violence, such as abuse of the child, may be disclosed by the child or from another family member. See section below on *service provider's legal obligation to report.*

Contextual stress and cumulative stresses have been identified as contributors to the co-occurrences of different forms of domestic violence, therefore, care providers must assess the stresses experienced by the family and the likelihood of child abuse by either parent (Margolin, 2005, p. 77). Identifying how long the violence has been going on and the types of violence the child has been exposed to is critical for identifying appropriate interventions. Factors that may play a part in how the child is affected include: severity of

violence witnessed, frequency of violence, gender of child, age of child, ethnicity of the child, maternal stress, quality of child rearing, family dynamics, time of exposure to violence, and the impact of shelter residence if applicable. Becoming aware of the child's perceptions of the violence in the home will also reduce the likelihood of re-traumatizing the child by discussion experiences of violence they themselves did not see or experience.

In understanding the child's reaction to violence or experience of violence, one must consider the interplay between what children bring to the contexts of their day-to-day lives and relationships and what these contexts offer (emotional support, investment of adult time and energy) (Margolin, 2005). Children who can acknowledge their traumatic experiences by talking about them may require different forms of intervention from those who cannot (Groves, 2006). General information to gather about the child that can help with this assessment can include: current level of functioning, developmental status, strengths, coping skills, vulnerabilities, problems and/or parental concerns, abuse status, and a general sense of how the child has been affected by witnessing violence in the family (Peled & Davis, 1995). Be aware of the ways in which a child's interpretation of and reaction to the violence are related to the effects they manifest. See section above on *effects of witnessing violence.*

It is important to note that while many children will, not all children exposed to violence suffer significant harmful effects (Salcido Carter, Weithorn, & Behrman, 1999; Drotar et al, 2003). Children may not require an intervention if: they do not demonstrate emotional distress, have good coping abilities and support systems; have not been exposed to lengthy or disturbing violence; or do not show any interest in intervention (Cunningham & Baker, 2003).

3. Confidentiality

It is important to discuss confidentiality with all family members from the beginning of their involvement with an agency. Explaining what confidentiality entails as well as exceptions to confidentiality are critical. Exceptions when the service provider would need to break confidentiality include:

1. if abuse of a child is suspected or disclosed,
2. if suicide is a concern either because a client says they have suicidal thoughts or the service provider is led to believe it is a concern,
3. the threat or intent to harm others is a concern, and
4. in the rare case of being subpoenaed.

These guidelines are consistent with the codes of ethics for the Canadian Professional Counsellors Association, Canadian Psychological Association, and the Canadian Association of Social Workers – see Recommended Resources for web addresses.

4. Safety Issues

Assessment must include safety issues and safety planning. Assurance of safety for victims, both psychological and physical, is a prerequisite for any form of intervention (Stover, 2005). Children cannot begin to recover from the effects of exposure to violence if they continue to be exposed to the violence. If the child and non-abusing parent are still living in a dangerous situation, the primary task of the therapist is to help the clients find a safe living situation (Groves, 1999). Based on recommendations from the Office for Juvenile Justice and Delinquency Prevention, Cunningham and Baker (2003) consider the following:

1. Ensure safety of families as the first priority.
2. Once the family is safe, facilitate the woman's ability to live in continued safety and support her as a parent.
3. Address the needs of each child as they manifest using the best evidence on effective intervention.
4. Where appropriate and needed, have available an intervention specifically targeted at violence issues.

Because of the potential dangers, few family therapy programs include parents who behave abusively. Those that do will only work with those individuals who have done extensive work to change their violent behaviour (Salcido Carter, Weithorn, & Behrman, 1999, p.8). See section below on *who to include* for more information on this topic.

A) Service Provider's Legal Obligation to Report

Legally and ethically, service providers must report knowledge or suspicion of child abuse; this concern supersedes confidentiality. Another situation which supersedes confidentiality is becoming aware that a client (adult or child) has threatened to hurt someone else. Because there is a high co-relation between children witnessing domestic violence and being a victim of direct violence or abuse, individuals working with this population *must* be prepared to deal with disclosure (Saunders, 2003; Groves; Salcido Carter, Weithorn, & Behrman, 1999; Dong et al, 2004). If the child discloses abuse they should be given the option of telling their parent (not the suspected abuser) about the abuse with the service provider in the room. Alternatively, the child may prefer the service providers to be the spokes-person. If the child is younger or service providers feel that the child should not speak with that parent, they may speak with that parent without the child in the room.

Close attention should be paid to the parent's reaction as there are many common reactions. If appropriate, their thoughts and feelings should be explored to get a sense of what they might need. Parents need to be told that child protection services must be informed, either by them, or by the service provider and these options should be discussed with the parent. If it is decided that the service provider will make the call, they should do so with the parent in the room so that they are clear on what information is given to child protection services. This knowledge of what was said will assure them of

the service providers openness and honesty regarding the issue and can help in future dealings with child protection services (Peled & Davis, 1995).

In the case where the disclosure of abuse is about the custodial parent, it is the responsibility of the service provider to explore the situation with that parent. The service provider must ensure that the disclosure is reported, however, discussing this with the parent directly before alerting the appropriate authorities may help maintain a working relationship with that custodial parent because the parent can better understand and experience the service provider's concerns about their relationship with their child.

B) Suicide and Self-Harm

There is a myth within western culture that children are not suicidal. Those who work with children need to recognize that this is a myth. Current statistics suggest that every year in the UK over 19,000 children attempt suicide - one every half hour (Marr & Field, 2001). In Canada, on average 294 youths die from suicide each year and many more attempt suicide. Suicide is the second highest cause of death for youth aged 10-24 (Canada Children's Rights Council). Children and youth's talk of suicide and self-harm must be taken seriously by service providers.

Service providers working with children must spend time thinking how they will talk about suicide with children, what to say regarding death and how to assess the level of risk. It is important to listen to what children say and to validate and normalize their feelings. Service providers need to be able to identify the talk as either an expression of feelings or a real intent. For example, some children will talk about wanting to end this life to go to heaven or come back in another life, which is likely a way of expressing deep feelings of frustration regarding for their life situation. Reasons why children may consider or act on suicide include:

- Attempt to regain control in their lives
- Retaliation or revenge against real or perceived wrongs
- Fantasies about reunion with loved ones who have died
- Relief or escape from unbearable pain
- Seeing themselves as the family scapegoat
- To distract the family from other issues such as divorce
- Acting out a covert or overt desire of a parent to be rid of the child

(Centre for Suicide Prevention, referencing Goldman & Beardslee, p.429).

While confidentiality is a concern, sharing suicide or self-harm issues with parents is necessary. When working with adolescents sharing this information with parents needs to be done with particular care so as not to lose hard-earned trust with the adolescent. When considering bringing in outside resources, thought needs to be given to how to do so, so that the child does not feel shamed in the process. Additional types of counselling, resources, follow-up services should be considered. When assessing the appropriate approach to addressing suicide and self-harm talk, determine what best fits with the agency.

5. Who to Include

Research indicates that children who have access to a parent are more resilient in response to trauma than children who do not have parental access (Groves, 2006). Yet parents' abilities to meet a child's needs for nurturing and support may be hampered by their own exposure to violence. Involving the non-abusive parent in counselling will established or reinforce their own supports, thereby making them more available to support their children as they move through the crisis (Salcido Carter, Weithorn, & Behrman, 1999). Resources that work to improve parent/child interactions must be available as these relationships must heal and adjust to the violence that has occurred (Salcido Carter, Weithorn, & Behrman, 1999). The literature makes it clear that involving the parent who did not use violence can significantly enhance the benefits of therapy for the child (Marshall et al, 1995; Peled & Davis, 1995; Rivett, Howarth & Harold, 2006; Cunningham & Baker, 2003). But what about the parent who did use violence?

The need for safety always taking precedence, there are mixed opinions on whether or how the parent who used violence should be involved in counselling. Service providers are advised to check to see if the agency they are working with has a mandate concerning this topic. If there is a prevention order denying the abuser access to the child or abused parent, then legally they cannot be part of the counselling. If the counselling takes place in a shelter, abusive partners are not permitted on the premises (they should, in fact, not know where the shelter is located). It is *not* advised that the parent who used violence become part of the counselling either right after the crisis or while the power imbalance that characterized the family relationship may be replayed, as this is detrimental to the non-abusive parent and the child. An assessment should be made about how the family members feel about inviting the abusive partner into counselling.

Timing is key when involving the parent who used violence. It is likely that the parent who has behaved abusively will only become involved in the rebuilding phase after some time has elapsed and there is greater likelihood for a balance of power. Some directives may come from the child or the parent who did not use violence. They may begin to ask about the behaviour of the other parent and begin to ask why he/she did what they did. This may indicate that their anger has decreased and they now need answers, perhaps answers that only the parent who used violence can provide. When the person who used violence is taking responsibility for their behaviour and they are aware of the impact of their behaviour they may be ready to engage in counselling with other family members. In some cases this will only be done after a thorough assessment of their behaviour and the risk to the family's safety.

There are cases where involvement of the parent who used violence in counselling may be advisable, for example, in cases where the parent will have an ongoing relationship with the child, such as visitation (Groves, 2006). Children who have therapeutic input and are provided with opportunities to have control over their visitation situation have improved likelihood of recovery from the trauma, especially when the visiting parent is counselled in strategies to help the child recover trust (McIntosh, 2002). This could be done by having the therapist meet with that parent to give guidance about the child's

complex feelings towards them and appropriate techniques for managing the child's behaviour. If the parent who behaved violently is interested in being involved in the child's treatment in any capacity, a number of steps need to be taken to ensure that physical and emotional safety of the child and the parent who did not use violence are addressed and ensured (Peled & Davis, 1995).

Whether or not a child has contact with a parent who has used violence should be determined on a case by case basis. The service provider must consider the child's experience of contact, and on both parents' capacity to respond to the needs of their child. The child must show a readiness for supported supervised contact, and the frequency and length of contact must be determined by this level of readiness (McIntosh, 2002). Forcing contact onto an unwilling child perpetuates the violence they have experienced. Counsellors should be aware that working with *all* family members could be viewed as a conflict of interest by any or all members, thereby putting in jeopardy the ability to provide effective therapeutic services (Groves, 2006).

6. Goal Setting

Goal oriented counselling gives direction to counselling and is strongly associated with positive therapeutic outcomes (Sharry, 2004). Goals should be individualized, manageable, and attainable. Clients should be central in developing goals, especially adolescents who can play a large role in goal setting. Clients come with skills and abilities, and goals developed should build on these. A family's goals will depend on their particular situation and will often reflect presenting issues for the child. Service providers should consider their role and the philosophy or mandate of their agency when working with families to articulate their long-term goals. The service provider's role is to keep these long-term goals in mind and have a sense for what kinds of things need to be covered throughout the therapeutic process to reach those goals.

While the service provider always has the family goals and therapeutic process in mind, short-term goals within a session should be in tune with the child's present needs. The pace, process and relationship building of each session should be based on what the child brings with them that day. A service provider needs to be willing to ask questions and follow the child's lead while working towards the family goals.

In addition to focusing the counselling, goals also fill an important role for evaluation of effectiveness in reaching the clients, counsellors and agency goals. Clear and specific goals are better guides to selecting the best strategies to achieve goals and to evaluate the progress towards those goals. Specific goal statements will be especially beneficial to children who think concretely rather than abstractly. Goal statements will also help service providers and agencies to track successes and redirect their approach when faced with less successful outcomes.

7. Record Keeping

It is advisable for service providers to keep files on the children and their families. The specific information kept in these files will likely vary from one agency to another. Below is a list of information and documents to be considered for inclusion in client files:

- Intake information on the child and/or family
- Specific instructions pertaining to the child such as medications, illness, and allergies
- Child's attendance in group and individual counselling
- Observation notes on the child's behaviour in programming/counseling sessions
- A record of the interactions between the child and each parent
- Record of contact with all family members or other parties such as teachers

In considering the type of information collected within the file, service providers need to consider who will have access to the file information. Because parents can have access to their children's file and because files can be subpoenaed, it is important to be cautious about the type and details of information kept. When recording information about the interactions between the child and their parent, service providers may only want to record factual observations and describe the behaviour rather than giving opinions or attaching meaning to the behaviour. For example, this would entail recording that the child was smiling during the interaction with their parent rather than recording that the child was happy. Because parents will likely have access to these files, a negative opinion or attached meaning to a behaviour may create strained interactions and lack of trust between parents and service providers.

Another issue to be addressed is the language used in the files. The language used should always ensure that the reader will understand the information. This means it needs to be accessible to parents as well as the courts if it is subpoenaed. To this end, it should be very plain in nature and terms and jargon specific to a particular field (counseling) should be avoided.

Further to who has access to file information, according to PHIPA (Personal Health Information Protection Act), no information about other parties can be made available to individuals. They only have access to their own information and in the case of parents, to information about their child. In addition, in many cases, the custodial parent determines what information about the child to which the non-custodial parent has access. In cases of joint custody both parents will have access to the file. Service providers must acquaint themselves with the particular legal obligations related to information sharing in their area before establishing their record keeping format and policy.

V: Counselling Preparation

1. Confidentiality

It is critical to be clear what confidentiality means right from the beginning. In some cases children need to be able to talk about what they learn in counselling with a supportive parent. In other cases, confidentiality establishes personal boundaries between child and parents. How confidentiality is addressed with the child will depend on their age. While for younger children the parents are more often involved in their therapeutic process, adolescents need to be given privacy and personal control over what information their parents receive about them. In addition to confidentiality being a complex concept, it is important to remember that children who have lived with domestic violence and who may themselves been abused, could have trouble understanding the difference between a bad secret and confidentiality (Peled and Davis, 1995; Sharry, 2004).

2. Obtaining Informed Consent

A) Children, Parents, Non-Custodian Parents

A service provider ethically must obtain informed consent from everyone involved in the counselling before continuing. Determine who the primary care giver is and what the custody situation is like. Agencies will have different policies and forms regarding informed consent for treatments with minor children. Individuals should consult with the agency and their supervisor/director as to the policies within their specific agency. Do not make assumptions about what one agency does because there is a lot of variation.

- If parents have joint custody, consent likely needs to come from both parents. Some agencies may ask parents to bring in custody documents. In some cases, if the non-custodial parent objects to their child participating in treatment, the child cannot receive treatment.
- Some agencies will only look for the consent of the primary caregiver. This is often done in the case of crisis or emergency shelters and agencies.
- Some agencies may seek the consent of the child, but in most, parental consent takes precedence.
- Some agencies will see children of 16 years of age without parental consent.

Consult the code of ethics or an ethical text should you have concerns regarding informed consent. Examples of consent forms are included in Appendix D.

B) Children in care

Consult with local child protective services regarding consent to treatment when a child is a permanent ward of the court. In general it is the child's social worker who gives

consent for their counselling. In Manitoba if a child is a permanent ward of the court, individuals should contact the Child Protective Service Agency for their specific policy on consent for treatment.

C) Informing the Child about the Counselling

Even if the child's consent is not required, ethically they should be informed about the counselling process. Ask the parent about if they have informed the child about the counselling. If they have, ask the parent or the child about how the child was informed. If they have not informed the child, inquire how they plan to do so (Peled & Davis, 1995). Confirm that the child understands why they are in counselling and what counselling involves. Children generally assume that they're coming because the family is coming but it is important that a service provider talk about it with the child. Explain to the child what counselling is and confirm a verbal understanding with the child. Examples include "do you know why you're here?", "do you think your family needs help?"

3. Preparation of children and families for counselling.

As mentioned above, stabilizing the child in a safe home situation is a necessary first step in successful therapy (Groves, 2006). In preparing them for counselling, tell them what will happen in counselling, what the sessions will be like, and particularly in a group setting, things that might arise in the sessions (for example another child may disclose that they have been abused). This preparation can give the child a sense of control and predictability over a new and potentially frightening situation (Peled and Davis, 1995).

It is generally useful to help non-abusive parents recognize the impact of violence on their children, increase the stability and routine in their children's lives, and find strategies to help the children cope (Groves, 2006). Victimized mothers may find it difficult to tolerate their children's expressions of sadness and loss for the abusive parent. Helping them to understand and cope with their child's feelings will increase the predictability of the situation decrease the likelihood of being unprepared to respond to things their child may talk about. These conversations can also be part of the parent's counselling. Discussions on how to respond to issues arising from the work their children are doing can be addressed with parents either in a group setting or individual counselling.

4. Counselling Room Set-up

Creating an environment of safety is critical for working with all children. Using pillows, comfortable chairs, couch, snack jar/cookie jar with food (note dietary precautions and consent) all contribute to atmosphere. Having a variety of toys, books, and craft supplies helps a child feel that they are welcome in this space and gives them options for how to

express themselves in a manner that is comfortable for them. See Appendix C for a list of specific ideas of what could be included.

VI: Methods of Intervention

There are many forms of counselling to consider for child witnesses and their families. This section provides an overview of current trends of intervention for this particular population. Using any of the following in a program or counselling setting should only be done with training.

The most widely described intervention for this population is group counselling, but benefits of individual counselling or a combination of several types should also be considered. Ultimately the type(s) of counselling selected will be based on the child's needs and what fits the family's situation. Whether or not, or how counselling involves the person who used violence is discussed under *Who gets invited as part of the counselling*. If issues related to the couple in the marriage or relationship is identified as affecting the child and their capacity to heal and cope, service providers should consider referring the adults to a service which specialize in intimate relationship counselling.

Children's age and counselling is a major consideration. While children of any age can be traumatized from witnessing violence, younger children have been shown to be at particular risk (Stover, 2005), because of their dependence and the fact that they are in the home all day. Even infants as young as two weeks have been observed to make organized attempts to defend themselves when caregivers do not and infants from at least six weeks show clear disturbances in response to spousal violence. Early supportive intervention is vital for mother-infant couples exposed to domestic violence. This is critical because a victimized mother can simultaneously be a source of comfort and of fear to the infant. (McIntosh, 2002). For young children (under age 6), individual interventions with strong parent counselling components are typically recommended as these children are too young to fully understand and to be part of their own counselling (Groves, 2006).

Group counselling is the most widely described intervention for children between six and 15, grouping children in age spans of two to three years (Groves, 2006). It is not uncommon for these programs to include concurrent groups for the mothers. "Groups can offer children a safe venue in which to talk about the violence, improve self-esteem and develop safety skills" (Salcido Carter, Weithorn, & Behrman, 1999, p.8). However, groups are generally not appropriate for children who have been more severely traumatized (Groves, 2006). Individual therapy may be recommended for children who show extreme symptoms (Salcido Carter, Weithorn, & Behrman, 1999). Extreme symptoms can reflect experiences of intense psychological trauma and related experiences such as PTSD. Because their needs are high and there are differences in the type and intensity of distress individual therapy will best be able to respond to their specific symptoms. Further, individual therapy gives the child the opportunity to disclose, in detail, the violence they have witnessed and allows time to explore the personal meanings embedded within the experience (Silvern, Karyl, Landis, 1995).

This guide outlines several therapeutic approaches to address the needs of child witnesses: groups for children, groups for parents, individual counselling for children,

individual counselling for parents, and integrated or combined approaches which can include any of the above. In considering what therapeutic approach to use with a particular child it is important to know that while attempts have been made to measure the benefits of various forms of therapy (including combined child and mother intervention), results appear to be quite varied due to a number of factors, in particular limited sample sizes and limited long-term follow-up. It does appear, however, that therapeutic interventions tend to have positive effects, and group interventions seem to be the most widely prescribed approach (Groves, 1999).

1. Models and Approaches

The overviews of the models and approaches that follow are intended to be descriptive of the various approaches. They are not prescriptive formulas. Applying them within a counselling setting requires specialized training.

A) Cognitive Approaches

Cognitive theories are based on the premise that thoughts impact on individuals emotions and behaviours. Thus, encouraging more rational thinking should lead to improved emotional wellbeing and more functional behaviours. Children that experience traumatic events will often formulate cognitive distortions or misperceptions about these experiences in an attempt to make sense of the event, gain a sense of control over the event and its consequences, or prevent the event from occurring again. The form their distortions take will be related to their level of cognitive development. For example, older children often have more complex distortions than younger children. Among the more common cognitive distortion evidenced in children and adolescents are self blame and taking on responsibility for the event, guilt, viewing all others as untrustworthy, having a negative view of themselves, others, and/or the world, misperceiving ambiguous events as threatening, and errors about the intent of the person who used violence (Cohen, Mannarino, Berliner, & Deblinger, 2000; Stallard, 2002). Self blame and personal responsibility often help children feel that they can control the event by changing their behaviour. Systems within the child's social environment can intentionally or unintentionally support these distortions (Cohen et al., 2000). For example, a parent who behaves abusively may claim that the noise the children were making made them so angry that they lashed out. Children's distortions and misperceptions are associated with emotional and behavioural symptoms (Cohen et al., 2000; Stallard, 2002).

Cognitive therapies attempt to address cognitive distortions and introduce more adaptive coping mechanisms by encouraging effective and accurate reasoning about the event (Cohen et al., 2000; Stallard, 2002). Most cognitive therapies have three basic steps: 1) talking about the event in order to identify the child's cognitive distortions; 2) joint child/therapist effort to examine the child's reasoning behind the distortion; and 3) replace the child's distortions with more accurate cognitions (Cohen et al., 2000). It is always important that these processes and discussions occur at the child's developmental

level (Stallard, 2002). Thus, some will involve the use of art and play to talk about the event, while others may utilize writing exercises. Replacing negative self talk with positive self talk is another cognitive technique that has been use with children and adolescents. Including parents in these types of cognitive therapies can be beneficial as it can ease their distress about their child's traumatic experiences, change their own cognitive distortions, improve parenting skills, gain support, and help their children continue the techniques they learned in therapy at home (Cohen et al., 2000; Stallard, 2002).

B) Emotion-focused Therapy (EFT)

EFT integrates client-centered, gestalt, and cognitive principles. With EFT, emotion is considered the prime mover in human experience. It provides the bases for the development of self and in part determines how individuals organize the components of their self concept (Greenberg, 2006). People are constantly in the process of making sense of their emotions, thus, the main goal of EFT is to help clients better understand their emotions so that they can learn to use their emotions to overcome their problems (McCarthy & Barber, 2004; Sloan, 2004).

According to Greenberg, the developer of EFT, there are several types of emotions. The fundamental, initial reactions to a situation constitute the primary emotions experienced such as being sad or at a loss. The feelings that mask the primary emotions are called secondary emotions. They are responses to thoughts or feelings rather than responses to a situation. For example, feeling angry in response to feeling hurt, afraid or guilty (Greenberg, 2006). In addition to primary and secondary emotions Greenberg says that people have adaptive and maladaptive emotions. Adaptive emotions provide a clearer, more balanced perspective of the environment and are a motivational source for goal achievement (McCarthy & Barber, 2004). Maladaptive emotions occur repeatedly leaving one feeling stuck and stale. Associated emotions include feeling hopeless, helpless, lonely, worthless and in despair. In short, EFT is the process of replacing or transforming maladaptive emotions into adaptive ones. The purpose of which is to promote problem solving and growth (Greenberg, 2006; McCarthy &Barber, 2004; Sloan, 2004).

An emotion-focused therapist is considered an emotion coach as they help people gain awareness and acceptance of their emotional experience (Greenberg, 2006). Other therapies work with emotion, but EFT is different in that it is empirically based. It is a systematic approach with therapist empathy as a core feature. From this base of empathy a therapist learns to listen first and use the client's emotions to guide the therapy.

EFT uses three main definable processes or goals to help clients to change their emotions. The first goal in EFT is *awareness* of primary emotions. Clients learn to hear what their emotions are telling them. The second goal is emotion *regulation*. These are generally overwhelming secondary emotions or primary maladaptive emotions which require regulating through breathing and relaxation. The third goal is *transforming* one

emotion into another. This is the most important goal as this is when clients are encouraged to "access other more adaptive emotions to transform, undo, or replace the maladaptive ones" (McCarthy & Barber, 2004, p.256). As part of this transformation, there is a need for the client to develop new narratives. A therapists role involves helping the client in "changing both emotional experience and the narratives in which they are embedded" (Greenberg, 2006, p.88).

EFT can be helpful for people who have difficulty dealing with difficult and intense emotions such as anger, sadness, fear, and shame. Greenberg suggests that children can benefit from EFT particularly if a parent is informed by it and are able to use EFT techniques to help their children shift their "emotional expressions into opportunities for intimacy and thereby enhance their children's emotional wisdom" (McCarthey & Barber, 2004, p.256).

C) Solution-focused Therapy (SFT)

Solution focused therapy (SFT) was first developed and described in 1986 by Steve de Shazer, Insoo Kim Berg, Scott D. Miller and staff at the Brief Family Therapy Centre in Milwaukee (Berg, 1994; Murphy, 1996). Generally considered to be brief therapy, it has underpinnings of strength-based approach with connections to narrative therapy and family therapy. It takes into consideration the client's resources, skills, competencies, goals and preferred futures. Instead of looking at client or family problems, it allows the clients expertise and capabilities to be honoured. The counsellor engages in problem-free talk with clients as people, distinct from their problems (Sharry, 2004).

The primary factor in SFT is its view of change as inevitable and constant. The understanding is that it is "easier to repeat already successful behavior patterns than it is to try to stop or change existing problematic behaviour" (Berg, 1994, p.10). In the clinical setting, activities are done to highlight and enhance successful behaviour patterns. Conversations often take on a flavour of "getting to know you." The strengths and goals that arise through this conversation can be drawn upon later in problem solving. SFT is not problem-phobic but builds on strengths of client's coping skills. Important components in this model include: pre-session change, exceptions, and goal setting (Berg, 1994; Tohn & Oshlay, 1996).

Pre-session change. Berg and others who developed this theory noticed that clients who attend counselling have often made positive changes to their life before they attend their first counselling session. By being aware of and paying attention to these changes, the service provider can help amplify and reinforce these changes. This can lead to quick solution finding. Asking clients about such changes is a good place to start and can assist the counselling process because solutions generated by the client, according to Berg (1994), tend to reduce the risk of setbacks.

Exceptions. Finding exceptions to behaviour is central to SFT. Service providers can help unravel what happened during those periods when the expected problem did not occur,

providing clues to how this new behaviour can be repeated. (Berg, 1994). Sometimes a client will be able to identify deliberate steps they took to make changes. In this situation, a service provider can simply encourage that they "do more of it." When exceptions appear random, service provider may need to be more involved in finding positive changes a client can make (Berg, 1994). Murphy (1996) describes recognizing exceptions to the problem as "changing the doing," meaning doing something different and changing ones usual performance of a problem or response to a problem. Another way of addressing or uncovering exceptions is by "change the viewing," or reframing in the problems in way that offers a different interpretation (Murphy, 1996).

Goal-Setting. SFT advocates goals-driven therapy. When clients are involved in developing their own goals they are more likely to meet them. Building empathy with clients is necessary in developing these goals (Sharry, 2004). Berg also emphasizes that when the goal is met, the task of meeting has been accomplished and the worker-client relationship ends.

The use of scaled questions (e.g. clients respond to statements on a scale from one to seven), is common is SFT (Tohn & Oshlay, 1996). These questions help clients and workers to identify what they think of situations. They can be used to help a client identify the steps they need to take to solve a problem. They can be used for motivation, to assess progress, to assess a relationship etc. (Berg, 1994). Scaled questions can be used by children as soon as they understand number concepts such as ten is greater than five. Generally seven or eight year olds can work with scales. When working with children it is helpful to accompany the question with a visual scale. Regardless of the age of the client, questions should be carefully worded. For younger children visual scales using faces that go from frowning to smiling are available.

D) Narrative therapy

It is essentially a series of collaborative conversations between the client and the worker where the client uses their own language to explain their experience and identify the problem. This contrasts with traditional forms of therapy where the problem is identified by the worker (Zimmerman & Beaudoin, 2002). A basic assumption of narrative therapy is that knowledge is socially constructed and ideas are culturally informed. Michael White, a major figure in the development of narrative therapy, draws heavily from Foucault's understanding of knowledge and power and how these feed into individuals' culturally-based understanding of their experiences and the language that is used to express these experiences (White and Epston, 1990).The therapist's role is to help the client draw out *their own meanings* out of their experiences and identify what they "want for their lives and how this connects to what they want from therapy" (Smith, 1997, p.26).

Because it is based on the concept of storytelling, narrative therapy is a good fit with children. Storytelling is a natural form of communication for children as it allows them the opportunity to use metaphors and images that make sense within their world. They can express both meanings and feelings about an experience using their own language

which is different from everyday or adult language (Sunderland, 2000, p.35). Children can be encouraged to enhance their storytelling through the use of other media, such as art or clay (Geldard & Geldard, 2002). Narrative therapists also use other creative outlets for children to express themselves using their own language and try to ensure that children can express their voice and story without being co-opted by an adult (Smith, 1997). The child can speak at their own pace and the therapist can follow their spontaneous discussion and questions.
A central concept of narrative therapy is externalizing the problem (White & Epston, 1990). As the client tells their story, the therapist poses questions to the client to help them identify the problem in their life and then separate their self from the problem. Through this questioning the therapists helps the client learn to separate the problems in their life from their identity (Geldard & Geldard, 2002). By externalizing the problem it can be treated as an issues that is outside of the client but is affecting the client. The client is encouraged to view the problem as taking place within the story, not the person, and then re-develop their stories in a way that separates the person from presenting problem or issue. (Smith, 1997; Zimmerman & Beaudoin, 2002).

The therapist helps the client identify life experiences where the problem story is contradicted and/or where the problem did not play a prominent role in the story. The client is then encouraged to re-develop the stories of their life so that the problem no longer dominates the narrative (Zimmerman & Beaudoin, 2002). This is called re-authoring as clients re-tell their stories in more empowering ways (Smith, 1997). Shifting language use which supports the re-creation of their life story is an important aspect of this process (Geldard & Geldard, 2002). The therapist is considered a co-author in this process as it is their role to draw out clients experiences and encourage ways of re-authoring an experience. (Smith, 1997; Zimmerman & Beaudoin, 2002)

These conversations help the client identify a version of themselves which they prefer and ultimately strengthen a sense of agency around these preferences (Zimmerman & Beaudoin, 2002). Through this process, the child develops a different view of themselves, thereby enhancing self-perception. Helping the child hold onto the new story is an important task of the counsellor (Geldard & Geldard, 2002).

E) Parent-Child Interaction Theory (PCIT)

Developed by Sheila Eyberg, parent child interaction therapy (PCIT) is based on Baumrind's construction of authoritative parenting and includes elements from family systems, learning theory, attachment theory, and play therapy (Storch & Floyd, 2005; Urquiza, 2004). Essentially, a parent training program, PCIT has been shown to be effective for families with negative interaction patterns particularly when the child is considered to be aggressive and/or have chronic behavioural problems, such as being oppositional, defiant or noncompliant (Urquiza, 2004; Urquiza & McNeil, 1996). Through direct coaching by the therapist, PCIT works to restructure parent-child interaction patterns by decreasing the externalized behavior problems and increasing the positive parent or caregiver behaviours to improve the quality of the parent-child relationship (Urquiza, 2004, Borrego, Urquiza, Rasmussen, & Zebell, 1999). It has been

shown to be particularly effective with children ages two to eight (Urquiza, 2004; Urquiza & McNeil, 1996).

Because it is based on general core concepts and works with families individually, PCIT is considered very adaptive as it can be tailored to individual situations (Eyberg, 2005). This includes families from different cultural backgrounds and families with children who have developmental disabilities (Storch & Floyd, 2005). It has also been demonstrated to be effective with families at risk for, or who have a history of abusive relationships (Urquiza, 2004; Urquiza and McNeil, 1996). Because statistics demonstrate that children who witness domestic violence are highly likely to also experience other forms of abuse, PCIT can be a particularly suitable model to consider when working with this population. For families with high levels of parental distress and/or risk for physical abuse, it is suggested that the PCIT emphasis on direct coaching may be more beneficial than group training (Urquiza & McNeil, 1996).

PCIT is conducted in two phases, each of which is approximately six sessions. The process is structured for parents to learn new skills while their child is learning new behaviours (Eyberg, 2005). Throughout both phases the therapist is in an adjoining room and observes the specific behaviors and interpersonal dynamics of the parent and child. The therapist provides coaching to the parent through an FM-signal audio reception device, or "bug-in-the- ear." Through prompts, directions, instructions, feedback and praise for the parent, the therapist supports the parent to respond appropriately to the child (Eyberg, 2005; Urquiza, 2004; Urquiza & McNeil, 1996). An example of direct coaching is through encouraging the parent to increase their use of descriptions: "By describing what the child is doing, the mother focuses on the child's ongoing activities, and increases the chance of noticing and praising desirable behavior. In addition, the child decreased his negative behaviors such as crying, whining," (Borrego et al, 1999, p.338)

The first phase, child-directed interaction (CDI) is about following the child's lead. It works at re-structuring the parent-child relationship by enhancing the positive interactions and decreasing the negative interactions between them (Borrego et al, 1999, Eyberg, 2005; Urquiza, 2004; Storch & Floyd, 2005). Parents are coached to follow the child's lead in play and are taught specific skills and behaviour with emphasis on the function of the behaviours behind these skills (Eyberg, 2005). The second phase, parent-directed interaction (PDI), is about leading the child. This focuses on improving the behaviour management techniques of the parent in addressing disruptive behaviour (Borrego et al, 1999; Eyberg, 2005; Urquiza, 2004; Storch & Floyd, 2005). The therapist coaches the parent through commands and directions in a way that builds on the positive interactions that were established during CDI (Storch & Floyd, 2005; Urquiza, 2004).

F) Play Therapy

Play therapy builds on, reflects and incorporates a number of the theories outlined above. Communication is very different for children and adolescents than for adults (Sharry, 2004). Within a counselling context, providing a variety of ways for children to express

themselves non-verbally is critical. Activities and toys provide ways for children to tell their story: "Play provides a natural context for children to process their unconscious anxieties and work through them in a comfortable, safe environment" (Ross, 2004, p.38). Respect for a child's pace to discuss difficult subjects is very important. Providing a neutral space for the child and developing safe relationships is critical for these discussions to proceed. It is neither appropriate nor helpful to push children to talk about difficult subjects before they are ready. Making available toys, art materials, books, puppets, dress-up clothes, etc., gives the children the choice of how to express themselves in a way and at a pace that is comfortable for them. Play can be therapeutic for children and they will often talk about issues while they play. Thus, play can provide counsellors with the opportunity to learn about the child's experience. The counsellor can follow their lead and learn from the child in a manner that is comfortable for the child. (Groves, 1999). Play can also provide a vehicle for service providers to introduce new ways of viewing the abuse, of perceiving their family members, of dealing with change, and of dealing with their feelings.

In selecting media or activities to use with children, service providers must take into consideration the developmental age of the children and the therapeutic goals. There are many therapeutic benefits for children when using media or activities which are suitable for their developmental stage and the goals which they are working towards. These can include: gaining mastery over issues and events, being powerful through physical expression, encouraging expression of emotions, developing problem-solving and decision-making skills, developing social skills, building self-concept and self-esteem, improving communication skills, and developing insight (Gellard & Gellard, 2002).

There are five basic categories of play and activity including: construction materials, artwork and drawing, reading and stories (could include video), puppets and figures, and worksheets and work books. When selecting activities, keep in mind that workbooks require a degree of cognitive ability and may not be suitable for special needs or younger children (Sharry, 2004). Note that any actions or forms of play that may not be helpful or may have been part of the abusive situation should be assessed. These activities are intended to create feelings of comfort, safety and trust and if it replicates something that is associated with abuse (i.e. their father made them go and play with their puppet or coloring book while he abused the mother) then it will not be helpful. Some suggestions for ways to incorporate play include:

- Puppets used as a way to discuss feelings.
- Arts and crafts used to calm children down (reduce arousal).
- Stories and videos used to introduce or cover relevant topics.
- Kaleidoscopes used as a symbol for change.
- Feelings posters with many faces of different feelings used as a tool for helping children understand about the variety of feelings and to identify their own and other peoples emotions.

(If you are interested in learning more about these theories, please see references section)

2. Group Counselling

Sharry (2004) highlights five significant ways that groups can be beneficial to their participants.

1. *Group support* comes from the significant realization that an individual is not alone in their experiences.
2. *Group learning* develops as participants share ideas with supportive peers.
3. *Group optimism* occurs when clients are inspired by the life-changing solutions that others have successfully integrated into their lives.
4. *Opportunity to help others* through meaningfully contributing to others lives gives value to the group and to the individual who is offering help.
5. *Group empowerment* develops when those with common experiences feel encouraged to make changes that they might not have felt capable of alone.

These characteristics hold true regardless of the ages of the participants.

While solid program evaluations for groups are limited, a thorough evaluation of groups for children who have witnessed violence in London Ontario was completed in 1995 (Marshall, Miller, Miller-Hewitt, Suderman, Watson, 1995). The children and mothers completed pre and post test evaluations. Results showed satisfaction from both mothers and children/teens indicating that the evaluated groups were successful in meeting their short-term objectives. These included:

- To increase the children's and adolescents' knowledge of safe behaviour during violent episodes;
- To encourage expression of emotions about the violence;
- To improve their own approaches to handling conflict with peers;
- To improve their knowledge and attitudes with regard to woman abuse and excuses for violence (Marshall et al, 1995, p.1).

A) Children's Groups

i) Advantages of Groups

For children, participation in a group provides opportunities to learn from each other while establishing friendships and connections. This is a significant advantage as relationships with peers are very important to children and the importance of these increases as they get older and move into adolescents (Sharry, 2004). The opportunity to engage in socialization can be particularly significant at a time when children may be away from friends, schools or other peer groups. A child's sense of isolation may be reduced through hearing peers talk about their experience. This may also encourage them to share their own experiences. Children will feel more comfortable telling their stories by being with others who can identify with their experiences. For adolescents, this is of particular importance, as peer identification is critical (Groves, 1999). Developing peer networks has the additional benefit of acting as a coping resource (Rivett, et al., 2006).

Further, groups can assist children with developmental tasks such as self regulation and self expression.

ii) Group Goals

Sharry (2004) stresses the importance of goal identification for children and youth. Forming a group identity that has a positive focus on participants' goals can provide an environment of beneficial group work. Among some of the most common goals listed are (Marshall et al., 1995; Peled & Davies, 1995):

- Helping children talk about the violence.
- Reducing the harmful effects of witnessing violence and improving children's behavioural, social and emotional functioning.
- Introducing enough change to prevent violence in the child's future relationships.
- Helping children develop a safety plan to use if they encounter violent situations in their future and generally helping children to protect themselves.
- Strengthening children's self esteem.
- Creating a safe and fun environment in which children can have positive experiences.

These types of goals can be found in The Community Group Treatment Program in London Ontario which offers three different combinations of groups, including child-only, parent-child (mothers attend half the sessions) and parallel integrated (mothers attend all sessions). The Domestic Abuse Project (DAP), groups for children developed by Peled and Davis (1995) in Minneapolis also present some of these goals. DAP is currently the model that has been adapted by a number of programs working with child witnesses (Rivett, et al., 2006; Cunningham & Baker, 2003).

iii) Core Content

Although different programs sometimes focus on or place emphasis on different content material, most have similar core areas of coverage. Among these core content areas are:

- Sharing personal experiences.
- Identifying and expressing emotions around the violence (separation, blame, loss).
- Defining violence.
- Dispelling myths regarding violence in the family.
- Separation and divorce.
- Personal power.
- Coping strategies.
- Learning constructive conflict resolution strategies.
- Developing safety plans including information about community resources.
- Prevention/detection issues around sexual abuse.

These core content areas can be found in the Community Group Treatment Program in London Ontario (Marshall et al, 1995) and the DAP in Minneapolis (Peled & Davis, 1995; Peled & Edleson, 1995). While these are in general important topics for any group

of child witnesses, with adolescents it is also important to include topics around healthy relationships and dating violence.

iv) Format

a) Closed vs. Open Groups

Closed groups have a set membership and set commencement and termination times. Open groups have a more fluid membership, with the possibility of some members leaving and new ones joining at each session. It is generally recommended that for treatment purposes closed membership is preferred for a greater sense of cohesion and the establishment of group roles and norms (Ross, 2004). However, open groups may be best when the population being served is transient, as the group composition will always be changing.

b) Group Make-up

1) *Ages of Children.* Typically children should be grouped in age spans of two to three years: 4-6, 7–9, 10-12. Groups can also be divided based on developmental abilities, including consideration for social skills and ability to concentrate. Generally groups are less helpful to preschoolers both because of their impulsive tendencies and peer groups are less important to them. It is recommended that preschoolers be involved in parent-child counselling (see below) (Groves, 1999).

2) *Group Size.* The number of children involved in a group should be determined by the needs and characteristics of the group members. This is often related to the ages of the children, although special needs is also a significant consideration. The type of issues being addressed will also be a factor in group size. Toseland and Rivas (2001) suggest the group "should be small enough to accomplish the group purpose and large enough so that the members have a fulfilling experience" (Ross, 2004, p.47). Younger children will require a smaller group to be effective. In general, it is recommended that the group consist of five children for every counsellor. However, this will depend on the ages, maturity level, and special needs of the children as well as the staff availability. It is important to keep in mind that there will likely be one or two children who drop out.

3) *Siblings.* If possible, it is preferable to have siblings in separate groups to give each child more freedom to discuss their family and to prevent family dynamics from interfering in therapeutic opportunities.

4) *Minority Issues.* These include gender, race and ethnicity, children with disabilities, and sexual orientation of parents. In general it is preferable that children not carry a minority status within a group. Gender and race and ethnicity tend to be more straightforward to balance. If possible, try to avoid minority

status for one child, for example, try to have a mix of genders and ideally not only one child of a gender. If you have one child of a gender or race or ethnicity, consider their personality, social and emotional development as well as those of the other group members in determining whether or not this is the right group for them. Peled and Davis (1995) recommend that the group facilitators initiate a conversation with the child and parents before a child joins a group in what would be a minority status.

When the minority status of the child is related to a disability, the facilitators need to assess their own comfort level and experience working with the child's particular disability. When the minority status is the sexual orientation of a parent, the facilitators must be aware of additional issues such as whether or not the parents have gone public with their sexual orientation and how this may compound the effects of family violence and programming. For example, children may not feel that they can share information about their family if it is not known that their parents are gay or lesbian. In these cases, it may be advisable to consider individual counselling or a specific group that addresses their particular needs (Peled & Davis, 1995).

5) *Physical and Sexual Abuse Histories.* It is important to remember that many children who witness domestic violence will also have experienced abuse. Facilitators need to decide in the planning stage how they will address this situation. If the child has previously disclosed and addressed their abuse through therapy, a group scenario may work for them. If disclosure takes place in the intake stage the child may be referred to another program. If disclosure takes place during the group it is important to allow them to continue with the group and consider referral to additional therapy at the end of the session. Be aware that there may be a sense of alienation if they are the only ones who disclose. Preparing all the children at intake for the possibility that others in the group may have been abused is important (Peled and Davis, 1995).

6) *Things to Consider When Putting Together a Group*
Group work is tough. Group leaders must be flexible, creative and not overly committed to a particular structure as it may not fit with a particular group of children. It is challenging, often impossible to get a homogeneous group of children, i.e. similar age-groups. Further, because participating in a group is unknown, most children will exhibit some resistance to groups. This is a natural reaction to this stressful experience. It is important to keep in mind that each child is unique and what may be the best approach for some will not be so for others (Peled & Davis, 1995; Peled & Edleson, 1995; Sharry, 2004; Geldard & Geldard, 2000, Cunningham & Baker, 2003). The following is a list of child characteristics and circumstances that *may* indicate that group programs may not be appropriate for a given child:
    - Children who are diagnosed with severe mental health issues.
    - Children who are developmentally delayed such that they can not function in a group setting.

- Children who display *highly* disruptive behaviour.
- Children whose substance use may interfere with the group.

c) Session Length, Frequency, and Duration

The length of the session should be determined by the age and/or developmental stage of the children. A general suggestion could be 30 minutes for ages four to five, one hour for ages six and older , and 75 to 90 minutes for adolescents. While some sources recommend that group programs last between six and ten weeks, research suggests that a minimum of ten sessions is required for group work to be effective with children (Sweeney & Homeyer, 1999, as referenced by Ross, 2004). The London and Minneapolis groups outlined above both had ten sessions. It is recommended that children who miss more than two sessions join a new group and start the sessions again as they will have missed out on core content and group building, which are integral to their own learning and the learning of the other children in the group. It is important to note that the first month of meetings will focus on building relationships within the group that will be essential to sharing experiences and working and learning together. Children must not be pressured into disclosures, sharing and dealing with the violence they have experienced. Facilitators must allow them to proceed at their own pace and to give them time to build the trust they will need to feel safe in addressing violence related issues.

d) Group Guidelines

Group guidelines are very important when facilitating groups with children. The following are recommended strategies to consider (Sharry, 2004; Peled and Davis, 1995):

i. Establish and agree to group rules from the beginning.
ii. Be clear and focused when asking children to do things and when reminding them of the rules.
iii. Attend to and reinforce positive behaviours.
iv. Ignore minor breaches. This includes behaviour that would not disrupt or offend the group. Each leader will need to determine what this means for them, but examples could include late attendance for the first meeting or interrupting others.
v. Structure the group setting in a way that promotes the rules.
vi. Think through how to deal with a child who is continually disruptive.
vii. Recruit parents' support in discipline strategies.
viii. Clarify the need for confidentiality and explain what it means – see 5. below.

Established guidelines when working with adolescents are also critical to the success of the group. Limits and consequences need to be clear to participants. Involving the group in negotiating group rules as well as content of the sessions can be provide good opportunities for bonding and learning. The degree to which this is done will depend on the ages of the participants (Sharry, 2004). Adolescents can be empowered by

involvement in such decision making. It may also make them more committed to the group and the guidelines they had input in establishing.

e) Structure

Routine and structure in the group are very important with children, particularly when other aspects of their life are not predictable. No matter what the age or relationship of group participants, it is critical that the person leading the group is well prepared and is able to provide this structure. Without thorough preparation the groups success can be severely compromised (Sharry, 2004). Other important considerations for children's groups are taking breaks and snack time. Breaks are important simply because the emotional work can be exhausting. Snacks demonstrate a basic form of nurturance and they can serve to develop a sense of comfort and safety within the group. Consideration of children's dietary needs, allergies, and preferences are important in making snack time safe and pleasurable for all the children. Service providers should obtain written consent from parents which outlines the types of foods allowed and not allowed and any medications that their child may be taking or that will have to be administered by the service providers. This takes the obligation off of the children to inform the service providers about any special requirements.

v) Confidentiality

It is critical to be clear what confidentiality means right from the beginning. In some cases children need to be able to talk about what they learn in groups with a supportive parent. In other cases, confidentiality establishes personal boundaries between child and parents. How confidentiality is addressed with the group will depend on the ages of the group participants. While for younger children the parents are more often involved in their therapeutic process, adolescents need to be given privacy and personal control over what information their parents receive about them. In addition to confidentiality being a complex concept, it is important to remember that children who have lived with domestic violence and who may themselves been abused, could have trouble understanding the difference between a bad secret and confidentiality. Service providers should help children understand the difference between their own stories, experiences and learned information, which they can share with family, and the stories and experiences that other children, which are private and not to be discussed outside the group (Peled and Davis, 1995; Sharry, 2004).

vi) Activities

When working with children, flexibility is necessary. Certain activities may not work with a particular group. It will be helpful for the service provider to have an alternate activity prepared in the event of this occurrence. Further, due to diverse needs and reduced attention spans, children's group sessions are faster paced than adult groups. Children require a variety of activities and tasks and cognitive exercises need to be

balanced by expressive exercises. Sessions should be well planned and highly structured with specific goals, educational activities, and breaks.

Examples of session goals include: define violence and responsibility for violence; express feelings including anger; improve communication; problem-solving and cognitive coping skills; increase self-esteem; develop social support networks; and develop safety plans. Examples of structured activities could include presentations, discussions, modeling, role playing, art projects, and homework assignments. Worksheets can be used in a group to help children share different points of view. Specific activities may include:

- Games such as healthy relationships bingo or anger bingo can be modified to suit different age groups.
- Collages can be worked on by the large group or smaller groups. Many topics can be addressed through the use of collages, such as "if I was in charge in the world, " or "cope don't mope."
- The Magic Coloring Book offers the opportunity to teach children to consider different ways of looking at a situation and different ways of coping or action.
- Stories from books that cover relevant topics (Elf books, Mercer Meyer books, Franklin books).
- Puppet play can be used to have discussions about feelings or an alternate to role play for younger children .
- Videos on relevant topics. Different videos can be chosen for different ages.
- Other Games and activities for troubled children and youth can be found in Liana Lowenstein's books

See appendix and recommended resources for more activity ideas.

When working with adolescents, it is important to balance both activities and expressive exercises even though their cognitive and conversation skills are at a higher level than younger children's. For adolescents the social aspect of the group will be very important. This can be encouraged through less formal recreational activities such as playing pool. Activities with this age group will likely be better received when group member are involved in the planning of activities. Ages 11 to 16 is a time of increased privacy, self-consciousness and awkwardness, so using alternative ways to discuss difficult topics can ease the pressures the youth may feel in these conversations. (Sharry, 2004)

vii) Parental involvement in groups

In the case of interventions with younger children it is often desirable to have some parental involvement within the group (Sharry, 2004). Peled and Davis (1995) suggest the following opportunities for parental involvement: at the intake session, during group orientation, participation in a parallel parenting group (see section below), and in a closing family session. Parent's should be made aware of the content of the child's group sessions. This will make it easier for the child to share their feelings about the group with their parent as well as prepare the parent for their child's possible reactions to the group.

Parent's will also be better able to reinforce issues and behaviours discussed the group (Peled & Davis, 1995). With adolescents, parental involvement will be determined by many factors, including how much privacy the youth needs (See section on confidentiality above)

B. Parent Groups

As noted above in the section on family systems approaches, children do not live in isolation. It is beneficial to work with parents, most notably due to children's need for support from those closest to them in processing their experiences. Groups are one setting in which parental counseling can take place. Groups for parents come in many forms including: mother-only, father-only, victim/survivor, and groups for parents who use violence. In general, the gender-specific groups tend to be based on the premise that it is women who are victims of domestic violence and men who behave violently. Individuals who do not fit these roles, including individuals in same-sex relationships, may have difficulty finding a group in which they feel comfortable. While it is advantageous for all parents to have access to parenting groups, victims/survivors and those who use violence should not be in the same group.

Many of the goals and topics covered will be similar in parenting groups for victim/survivors and in groups for parents who have used violence. However, there will be additional issues to address that are specific to the common experiences of either those who are the victims/survivors of the abuse and those who have used violence. Because the literature tends to offer recommendations for gender-specific groups, this guide will do likewise.

It is also cautioned that a professional not attempt to meet the needs of all parties, i.e., the children, victim/survivor of abuse and the parent who used violence. Conflicts of interest may arise and the situation may be particularly confusing for a child if they are aware that a service provider is working with them and with the parent who used violence (Groves, 2006). For those service providers working with parents, it is important that they be aware of ethnic and cultural differences in parenting and attitudes in the group, including their own. They must also be vigilant for sexist, homophobic, and racist language. Avoiding assumptions, like that the mother is always the custodial parent will help service providers be more objective and responsive to the families needs (Peled & Davis, 1995).

i) Groups with Women who Experience Domestic Violence

Even if a group for women who experience domestic violence is intended to be a parenting group, there will be unique issues to address given the experiences of the group members. It is recommended by some that these women have access to counselling to address issues of their own experience as well as support for developing their parenting skills. Many women's groups are developed to be coordinated with their children's involvement in a group. These mothers groups can act as a place to share information

about the children's group while giving women the opportunity to do their own healing work. The Minneapolis DAP program (outlined above) is an example of this type of group.

a) Advantages of Groups

As explained above, there are a number of advantages to group work, including support, learning, optimism, opportunity to help others, and empowerment (Sharry, 2004). Groups can help women understand their children's experiences with and reactions to domestic violence and make them aware of what their children are learning through counselling. This information will facilitate their capacity to respond to their children's concerns and discussions and help them cope with the abuse.

Explaining domestic violence in the context of the wider system and providing a feminist perspective will allow for greater understanding of the factors that contribute to domestic violence in society and give women a broader view of the issue. A common reaction for women who have lived with abuse is to see themselves as bad mothers. Understanding the antecedents of partner violence can help women overcome their feelings of personal failure as they begin to conceptualize the range of contextual and personal issues that influence this type of behaviour. Groups can also help empower women to address their own personal needs by looking beyond their role as mother. Opportunities for women to share common experiences resulting from domestic violence (such as custody or other legal issues) are another valuable part of mother's groups.

b) Parenting Group Goals

The goals of groups for women who have experienced domestic violence can focus on any aspect of the experience. Those that are attached in someway to programming for children, will typically have a goal related to parenting. Encouraging new perspectives is another common focus for goals. Among the most frequently listed goals are:

a. Provide information
b. Challenge attitudes, values, beliefs, and assumptions
c. Create new insights
d. Develop parents' child-rearing skills

c) Core Content

As with children's groups the core content will depend on the primary goals and intent of the group. Generally the core content for groups for women experiencing domestic violence will include topics that promote understanding the effects of the violence on their children and themselves and on improving their parenting skills. Examples of core content are (Rivett, et al., 2006; Peled and Davis, 1995):

a. Effects on children of witnessing violence
b. Effects of early life experiences on parenting

c. Child development
d. Parents' rights/children's rights
e. Discipline versus punishment
f. Self-esteem in children
g. Communication
h. Changing families

ii) Groups with Men Who Use Violence

While family or couple therapy may fit some family contexts, it is often not possible for a variety of reasons, most often and importantly due to safety concerns. Groups are an effective way for parents who use violence to work through and address issues related to their behaviour. According to the literature, groups appear to be the preferred method for working with men who use violence. Reasons for this include: reducing their sense of isolation, mutual sharing, support, accountability, expressing their feelings, identifying inappropriate behaviour, and providing impetus for change, (Bennett & Williams, 1999; Blau & Long, 1999; Hamel, 2005; Williams, Boggess & Carter, 2001).

Pence and Paymare (1993) provide several helpful considerations to keep in mind when working with men who use violence. Screening participants is critical for a productive group environment. Substance abuse, psychological problems (including serious psychopathology), and disruptive behaviour, could jeopardize the creation of a positive climate for men to make changes. In some cases the answer may be to have a group made up of men who are resistant to working in groups. This could provide an opportunity for specialized programming without compromising the learning opportunities for men who want to attend a group. Pence and Paymar (1993) also recommend that programs with groups for men who use violence have contact with each man's partner. This has several benefits including providing the partner with accurate information about the group and obtaining information from her about her partner's abuse history.

There are concerns one must consider in preparing to develop groups for men who use violence. Key among these is how running such a group will be interpreted by children and mothers who are at the receiving end of this violence and/or witnesses to it. Yet working with those who use violence, can provide a unique opportunity to support the family unit and in particular the children.

a) Advantages

Working with men who use violence can help establish safety for the child/ren if the child is aware that their father is seeking help to address the violence and if they know he is taking responsibility for the violence. As with other groups, breaking the sense of isolation provides a context for healing and development to occur. Psychoeducational programs (which men's groups tend to be) are reported to have positive outcomes, however, there are limited long-term impact studies to rely on for useful evaluation (Blau & Long, 1999).

b) Disadvantages

It is important to remember that men seeking therapy because they have been court-mandated and may not be motivated to fully participate, at least initially. Other men who seek help on a more voluntary basis are often motivated to change in order to become a better parent and have a more positive, meaningful relationship with their children.

c) Goals

Most currant programs for men who use violence address non-violence issues using feminist-influenced concepts of male dominance and privilege. In general, these groups are psychoeducational, addressing child development, behaviour management, stress reduction techniques, and family interaction patterns. Groups are used to simultaneously re-educate and counsel men, and goals tend to fall in to the following categories:

- Information and sharing about violence
- Taking responsibility for violent behaviour
- Parenting skills
- Building foundations for hope and change

(Bennett and Williams, 1999; Mathews, 1995; Pence and Paymar, 1993; Williams, Boggess & Carter, 2001).

d) Content

While elements of the following content are considered outdated by some, emphasis on perpetrator accountability and challenging rigid gender biases with men who use violence are still considered to be critical content of such a group (Hamel, 2005). Content tends to included aspects of the following (Mathews, 1995; Pence and Paymar, 1993):

- Addressing Men's resistance to changing behaviour
    - Bad behaviour is not being a bad person
- Thinking and behaving skills
    - Anger management
    - Problem solving
    - Expressing feelings
    - Non-threatening behaviour
    - Respect
    - Sexual respect
    - Negotiation and fairness
    - Stress reduction
    - Social skills
    - Support, trust, accountability and honesty

- Addressing issues of shame
    - Looking at the history and cycles of family violence
    - Effects of early life experience on parenting
- Developing empathy for their children
    - effects of witnessing violence
- Parenting skills
    - developing knowledge of child development
    - addressing issues of step-parenting
- Committing to non-violent parenting
    - Discipline versus punishment
    - Logical and natural consequences

e) Format

1) Closed vs. Open Groups

Both closed and open groups can work well with men. The closed groups offer more structure and a greater opportunity for learning, practice of new skills, and building a sense of trust with other groups members. If the man is court mandated to treatment, it is likely that he will be mandated to a closed program with specific content and timelines. Open groups may be more appealing to men who enter programming on a voluntary basis and are not able to attend regularly due to employment or other circumstances. Some community agencies have men attend an open group as they wait to get into a closed group.

2) Group Make-up

i. *Group Size.* The average size of closed groups for men are eight to 12 members. Some groups will begin with 15, in preparation for some attrition. Beginning with eight may mean that only four or five remain at the end. Open groups ideally will also have eight to 12 participants, but with fluid membership, group size can vary widely from session to session.

ii. *Minority Issues.* It is very important that groups consider the need of men who come from minority groups. The literature demonstrates that when consideration is given to culture and groups are formed with an effort to reduce minority status of group members, trust is gained and men are more comfortable discussing their experiences including the impact of these experiences on their behaviour.

3) Session Length, Frequency, and Duration

The average session is two to three hours with a break included. Sessions are usually once or twice a week, with a total of eight to 32 meetings. Some programs are scheduled over four months, some six months, and some run up to one year. The programs that are primarily psychoeducational often off0er between six and 12 sessions in under three months.

3. Individual Counselling

There are several reasons why individual counselling may be advisable: individual goals or needs may be lost in a group, clients may not connect with the group members, and the group structure or set-up may not suit an individual's personality and situation. Personal goals, needs, format, location, meeting times can be customized in individual sessions (Sharry, 2004). Another time individual counselling may be appropriate is when a group is not available for a particular person's situation. For example, because groups are generally gender-based, a woman who has used violence or a man who has experienced violence may have a hard time finding a group with which to connect.

Use caution when deciding how to develop an intervention. Many approaches have not been tested for effectiveness and therefore their unintended side effects are unknown. Cunningham and Baker (2003) recommend a focus on treating the presenting problems such as trauma or conduct disorder. Each case needs to be considered individually when structuring intervention and strategies for intervention should only be selected after a thorough assessment of the individual case (Cunningham and Baker, 2003)

A) Parental Involvement in Children's Individual Counselling

Working with children means you are working with their caregiver and therefore, working individually with a child will still include a degree of parental involvement. Parents are required to be involved at intake and need to give their consent to the counselling (see section above on obtaining informed consent). They may also be involved at other points when it would be beneficial to the child. Taking into account the nature of the problem and progress made during individual counselling with the child, the counsellor will determine when parental involvement would be beneficial.

Parents have a right to know about how their child is doing in counselling. Service providers need to find a way to offer feedback to parents while maintaining some sense of confidentiality with the child. Developing this relationship with the parent by providing them with input may also enhance their commitment to the child's counselling. Suggestions of types of feedback to offer a parent include therapeutic methods used with the child and types of games played. Such information gives power to the parent concerning their child and can also help them understand the changes that are happening for the kids, which may surface in interactions in the home environment.

B) Child-focused Counselling

While group counselling is often the recommended intervention for working with child witnesses, individual sessions may sometimes be appropriate. In 1999, Groves reported that not a lot has been written on models and approaches for individual treatment for child witnesses. It appears this conclusion holds today. When working with children it is essential to keep in mind that the way a child experiences trauma depends on their developmental level. For example, school-age children have been found to adopt limited views of the world. This can impede their ability to make sense of and cope with the violence they witness at home. Children of this age may have a general distrust of adults, making a key role of the counsellor developing trusting relationship. This is also a reason why groups can be considered preferable for this school-age group (Hamel, 2005). Trust may be more easily developed with other children in a group situation.

i) Advantages

Depending on the family's culture, children can be reluctant to share intensely personal issues with a counsellor when other people, in particular other family members, are present. Individual counselling allows the counsellor the opportunity to build a trusting relationship with the child. This trust will facilitate more open information sharing, thereby helping the child process their experiences more fully (Geldard & Geldard, 2002). Because disruptive behaviour is more likely to be seen in groups than in individual sessions, individual sessions could be more fruitful for children who exhibit this type of behaviour.

ii) Goals

Goals of any work with children should include providing a comfortable space for open discussion about the child's experiences. Other helpful goals include: helping children to understand their emotional response and find healthy ways to cope with these emotions; identifying who is responsible for the violence and who is responsible for managing it; and reducing and managing the symptoms of the child's response to the violence.

iii) Core Content

Many concepts for individual work with child witnesses are similar to the content of group sessions. Important items to consider include helping children in (Rivett et al, 2006):

- understanding events that occur around them.
- minimizing distress and problems that follow from the distress.
- understanding who to blame and that they are not responsible for the violence.
- addressing self-blame and shame and sadness.

- learning appropriate ways of responding to domestic violence events, as some children are inclined to intervene.
- learning about why the conflict is occurring (this can help reduce blame on one parent or on the child themselves).
- resolving feelings of threat and address ongoing feelings of threat when the child has a conflict with either parent.
- differentiating non-violent and violent conflicts to moderate their levels of threat.
- resolving problems such as depression or anxiety.
- dealing with anger and other strong emotions.
- addressing complex feelings towards the abusive parent.

Severe symptoms such as PTSD may be best treated through individual counselling and some clinicians have adapted models for treating PTSD. While not all child witnesses exhibit PTSD they often share common symptoms such as anxiety, reliving the experience and dreaming about the experience. The content of counselling sessions includes stabilizing the life situation, integrating the experience in an adaptive manner, and working with the child to manage the symptoms of the trauma (Groves, 1999). A model adapted from treating PTSD at the *Child Witness to Violence Project* at Boston Medical Centre includes teachers and caregivers and encourages children to discuss traumatic events, identify their feelings and learn to manage their symptoms (Groves, 1999).

iv) Activities

In setting up for treatment certain supplies will have to be gathered such as: equipment, space, materials for play, resources needed (see Supplies Cupboard in Appendix C for suggestions). The supplies selected will depend on the ages of the children in counselling. Toys are particularly important resources and appropriate toys should be selected for the waiting room and the counselling room. Toys provide invitations for children to express themselves. There are some toys that counsellors may not initially consider. But that may be helpful in the therapeutic process. For example, if it is relevant to treatment and the traumatic issues experienced by the children, making sexually provocative or violent toys available will have to be considered. Although toy guns may make some counsellors uncomfortable, if guns are part of the child's life experience, they may be necessary to tell their story and thus helpful to the therapeutic purpose. Whatever toys are made available, it is important that all the pieces/components are intact to make them as appealing as possible to the children. Finally, in creating a safe environment it is important also to have food on hand. Food can be comforting and calming, and having snacks, like play, can provide an activity around which it becomes more comfortable discussing negative experiences and feelings.

v) When Individual Counselling is Not Appropriate

When the child is extremely young they will not be able to participate in individual counselling activities. In this case, working with the child and parent who did not use violence may be preferable to individual intervention. See section on *Combined Forms of Counselling* for details.

C) Parents

Counselling for all parents involved in domestic violence can be helpful. However, the majority of information is around counselling support for those who are the victims or survivors of domestic violence, as these are most often the parents continuing to be with and supporting the children. Generally these are women.

i) Parents Who are Victims of Domestic Violence

a) Advantages

A great deal of flexibility is gained when working individually with parents. The goals of the counselling can be customized to meet their specific needs. As well, other practical issues including when and where the meetings take place can be altered to fit their schedule.

b) Goals

Goals will vary depending on the needs of the client. Therapy for women who have experienced domestic violence should include autonomy and empowerment as therapeutic goals. This can help address common feelings and experiences such as feelings of being trapped, being subordinate, agitation, anxiety and depression (Blau & Long, 1999). An example of a program that works individually with parents is Project SUPPORT for mothers who, along with their children, are no longer living in a violent situation. This program provides support for the mother while teaching her child management skills (Cunningham & Baker, 2003).

c) Core Content

One of the best ways to help children is by helping mothers/the non-abusive parent to (Baker, 2006; Groves, 1999):

- understand how woman abuse affects parenting;

- make links to what past experiences of abuse may mean for mothering in the present;
- recognize the impact of the violence on their children and understand the coping strategies that children may use – emphasize that the children are also survivors and that strategies during time of abuse may not be helpful later on;
- provide a context for understanding their children's behaviour and their own struggles/challenges to parent;
- learn how to talk with their children about the experiences of violence;
- increase stability and routine in the home;
- develop coping strategies they can teach and encourage in their children;
- understand their children's mixed emotions towards the abusive parent.

Some discussion around ways to involve other community resources may be suitable, such as teachers or child care providers. Such involvement can help ensure consistency throughout the child's life (Groves, 1999). It is common for women coming out of abusive relationships to feel neither capable of parenting alone or secure in their parenting abilities. Bilinkoff (1995) recommends a number of ways of working with women to empower them as mothers as they work to balance nurturing and managerial roles within the family: developing an empowered vision of mothering, developing new family rituals, handling economic changes, developing an extended family network, recognizing the impact of the therapeutic work with the children.

ii) Parents Who Use Violence

Individual therapy is not the preferred option for parents who use violence. Exceptions to this may be individuals who have less severe problems with a strong support system and a partner willing to participate in couples counselling. Those with mental health issues may not benefit from a group and therefore individual therapy would be preferable. Part of this is due to the need to learn basic relationship skills, and groups provide a venue for the learning and practice of these skills (Hamel, 2005). See section on men's groups for details.

4. Combined Forms of Counselling

Like any discipline, there are service providers who believe that individual counselling is sufficient, some believe that family counselling is sufficient, and others believe that there are benefits for child witnesses to integrating or combining several forms of counselling. From a family systems perspective, violence is often affiliated with other significant family problems, therefore, intervention with a family must take place at all levels of the family system in order for it to be effective (Kashani & Allan, 1998). The literature makes it clear that involving the parent who did not use violence can significantly enhance the benefits of therapy for the child. Patterns are emerging which suggest that intervention with the parent along with help for the child is likely to yield the most positive outcome (Groves, 1999; Rivett et al, 2006). There are many ways that this

intervention can take place. Below, various forms of family therapy, concurrent groups, parent/child intervention, and combined group and individual counselling are discussed. Deciding what combination of counselling forms to use in a given situation will depend on: what information the children provide regarding where the work needs to be, the individuals, the context at hand, and the availability of programming options. If issues are raised that stem from the couple, referral for couple counselling may be recommended. See section below.

A) Family Therapy

The family needs to create a safe, stable and nurturing environment for the child to recover from the effects of witnessing domestic violence(Geldard & Geldard, 2002). This may require a therapist to address stressors in the household such as housing difficulties in addition to any therapeutic intervention. While most intervention models for child witnesses stress involvement of parents in some way, working with families plays an important role in the child's successful recovery. The degree of family work will depend on each case and may include therapeutic and advocacy-logistical work (Groves, 1999). Some counsellors and families may see fit to have further intentional family therapy.

Family therapy can include any number of combinations. The whole family, the non-abusive parent and children or other combinations. Some may want to include extended family or other community members (Hamel, 2005). Family therapy is based on the understanding that violence is a systemic problem and that violence in the household leads to a range of effects for both parents and children. One such effect is the disruption of the mother-child attachment that can happen when the mother is unable to protect or provide support for the child as a result of the violence she is experiencing (Hamel, 2005). Child-parent therapy provides an opportunity for this bond to be re-established and made healthy. Work with the entire family is most important if the family is hoping for reunification. It is seen as a unique opportunity through a unified treatment system: "the presence of the children provides a corrective check on the parents' tendency to minimize their abuse" (Hamel, 2005, p. 152).

Kashani and Allan (1998) recommend that therapists working with entire families, consider including the following content in their sessions:

- develop a non-violent contract to ensure the violence in the house is not continuing.
- find ways for the family to increase positive interactions (such as playing games).
- help increase social supports for all family members
- help the family members develop new tools to improve communication patterns through problem-solving and communication training.

Sharry (2004) suggests that service providers hold individual meetings before, during, after, family counselling. Another option is to integrate family therapy with individual counselling for one or more family members (Geldard & Geldard, 2002).

There are a number of situations where working with the family unit may not be the best approach. Family therapy should *not* proceed if: any family members are concerned about their safety; severe and/or unilateral battering occurred; either parent has severe mental health issues; and other factors are present that may allow a power imbalance to be perpetuated in the counselling session. In these cases, other forms of therapy should be pursued.

B) Mother (Parent) and Child Counseling

Current research suggests that infants as young as two months are aware of domestic violence, and several authors agree that any child who is affected by family trauma should be considered and helped (McIntosh, 2002). Practitioners need to consider the needs of very young children in their therapy and the skills they will require to help them. An essential component of counselling young children is nurturing the mother/infant bond. In working with preschoolers, including mothers is the preferred form of intervention (Groves, 1999). The *Child Trauma Research Project* at San Francisco General Hospital treats preschooler-mother pairs to help the child and mother address the effects of violence while strengthening the family unit. According to Groves (1999), involving the parents in some form of treatment with their children is a very important component to successful therapy as it helps stabilize the home situation. Theraplay, for example, can be a helpful form of intervention when family violence has affected attachment. Suggestions of activities to include in therapy nurturing attachment include using construction materials such as clay, play dough, and blocks, to encourage parent-child play. This is beneficial as it promotes an interaction that is relaxed and can open up communication between parents and children. Additionally, books can be introduced by the therapist in a session and can be used at home by the parents (Sharry, 2004).

C) Groups – Concurrent and Combined

It is common for services providing children's group interventions to also provide a separate, concurrent group for their mothers. Several studies indicate that children involved in groups are more likely to improve if they participate groups *while* their mothers participate in a parenting group. One of the benefits is that it offers an opportunity for parent's to address concerns about what their children are doing or discussing in the children's group. It is becoming increasingly clear that when mothers are involved with their children in a group setting or integrated counselling, the program can emphasize the effects of witnessing violence on children so that the mother can meet the needs of their child (Cunningham & Baker, 2003; Graham-Berman, 2000; Marshall et al, 1995; Peled & Davis, 1995; Rivett, et al., 2006).

Another version of concurrent groups is providing integrated group counselling, where mothers and children are in a group together. If a group includes parents and children, similar opportunities for sharing and learning together are maximized. In general, these sessions can last a little longer than if it is just with children.

D) Group and Individual Counselling

For some people, groups (including family therapy) can be beneficial in combination with individual counselling as each offers different but complimentary benefits (Sharry, 2004). For example, it is recommended that help for mothers come in the form of counselling services *in addition to* parenting services as the best possible scenario (Rivett et al, 2006).

E) Working with Couples

Counsellors working with families follow the child's lead regarding what issues need to be addressed. If the issues highlighted are within the couple system (two parents or caregivers), couples counselling may be advisable. Couples counselling requires specific knowledge, experience and screening. It is recommended that couples are referred counsellors or agencies with this expertise.

VII: Termination

Termination is a significant part of the counselling process that can be emotionally difficult for clients and service providers. There are a variety of circumstances that will bring counselling or programming to an end. Termination can be initiated by the client, service provider, or reach a natural conclusion such as a time-limited program being completed or pre-determined goals being reached.

1. Anticipated Termination

In general, the best form of termination is an expected termination that is mutually agreed upon. Anticipation of termination for a child is critical and therefore preparing for termination for weeks or months leading up to the event is beneficial to the process (Wallbridge & Osachuk, 1995). Preparation can consist of making a plan for termination and reminding children of the end date for the program/counselling. It may be helpful to use a calendar to help clients visualize the number of sessions remaining, especially for children. Discussions around changes that have happened throughout counselling can also be part of preparation for termination (Stewart, 1995). When discussing termination with children, it may be suitable to discuss issues of separation, abandonment and rejection (Geldard & Geldard, 2002).

When terminating counselling with people who have been exposed to domestic violence, the service provider should consider that the relationship which has been developed with the client may be one of their first or few experiences of trusting another person. In this situation, abrupt endings may cause the client to feel betrayed or abandoned. For this reason, careful planning is ideal (Cairns & Gilman, 1995, p.234), as is a more graduated termination process. For example, gradually reducing the frequency of the meetings will help the children to adjust to not being in counselling and stop the further fostering the counsellor/client relationship without creating feelings of abandonment (Wallbridge & Osachuk, 1995).

It is generally advisable to give the termination session special attention and include symbolic elements that represent achievements and transitions (Wallbridge & Osachuk, 1995). Ideas for this include: developing a ritual, holding a party, writing a letter, and offering a certificate highlighting goals achieved. Talking about memories, offering a small gift or transitional object (such as a card) to the child can also ease the transition (Boyes & Cairns, 1995). In a group setting, attention should be given to prepare both for leaving the group and the service; termination rituals should reflect this. It may be helpful to have a family session after the group has ended to help the child work through termination (Peled & Davis, 1995).

A safety plan should be done at the beginning of the counselling process and then should be reviewed leading up to termination, giving time for the service provider and clients to anticipate pit falls. At termination, the service provider can review the safety plan with

the clients, elements of which may be included in the termination session. For example, giving whistles as a symbol and as part of the safety plan.

Anticipated termination can allow time for a final assessment and evaluation with the child and their family. Evaluations may provide helpful information for the clients, the service provider and the agency. Because termination tends to be emotional and clients are thinking about a variety of issues within the last counselling session, it is recommended that evaluation occur several weeks before moving into the termination.

In some situations a counsellor may wish to maintain contact with clients as a follow-up for additional support (Geldard & Geldard, 2002). This additional support may include providing clients with contact names for other community agencies and programs. In other situations, simply informing the child or family that such follow-up is available, or following-up within a few months of termination may provide a sufficient sense of support. While follow-ups can be reassuring to parents (Boyes & Cairns, 1995), they are not always required or wanted. For this reason, service providers may want to do an assessment of whether follow-up is or is not required. This assessment will in part by agency policy.

2. Unexpected termination

There are many reasons for why counselling might end unexpectedly. A parent may withdraw a child or the whole family from counselling; one family member may no longer be willing to attend; a parent may withdraw consent for continued counselling; the counsellor may no longer be able to work with the family due to a conflict of interest[1] or another ethical dilemma; Child and Family Services or the justice system may be getting involved with the family; or the family may need to move. In a group setting, in addition to the above situations, the group dynamics may be unhealthy; the service provider may need to ask one person to leave; or they may have to end the group for a variety of reasons.

Anticipating the reality of unexpected terminations is another reason why it is helpful to make a plan before the expected time of termination, including *communicating about these issues with the children*. Providing on-going feedback is one way of ensuring that if the client leaves they will have received some of the benefits that come with termination, even if the termination session is limited or does not occur. Likewise, having mid-term evaluations of the counselling or a month before termination will provide the service provider with some feedback even if the session terminates unexpectedly. While the service provider may not be able to follow through on the complete plan of termination, elements of the plan may be carried out to a degree. It is important to make an effort to

[1] "Conflict of Interest is a situation in which someone in a position of trust…has competing professional or personal interests. Such competing interests can make it difficult to fulfill his or her duties impartially." (Wikipedia - http://en.wikipedia.org/wiki/Conflict_of_interest)

connect with the child, either by seeing them or by sending them a card (homemade cards are best as they are more personal and can be structured to the child's reading level). Finding ways to follow-up with the family can be helpful. Depending on the family's context and situation, it may make sense to do a check-in one month later via phone or a drop in. Give the family names of people and other agencies with which they can connect. It may be necessary to make other systems aware that termination has occurred.

3. Critical Steps in Termination

Regardless of the situation or how abruptly termination occurs, it is highly encouraged that at a minimum the service provider:

- ensure a safety plan is in place (the safety plan should have been developed from the beginning of the counselling),
- review what they have achieved,
- *try to see the child.* If this is not an option, sending a letter saying goodbye is advised.

4. Service Providers and Termination

Both clients and service provider have spent significant amounts of intense time together. It is natural to feel mixed emotions about the ending of that relationship. It can be helpful to address these feels with all clients, but is also critical that the service provider be aware of their own feelings around loss and endings. Some service providers may feel a sense of relief if they have been working with particularly challenging clients (Stewart, 1995). It is important for the service provider to be aware of their own boundaries and needs around these issues, seeking support and guidance from co-workers or a supervisor as necessary.

VIII: Evaluation

1. Program Evaluations

The value of evaluation is that it helps individuals determine if a particular program achieves its intended goals and does so in a cost effective way. This knowledge can then be the basis for program selection or modification. Evaluation is a process that should evolve along with the program itself and match each stage of program development. The developmental steps of program evaluation would then evolve as follows:

A) Needs Assessment

A needs assessment determines if there is an issue that needs to be addressed. It includes an investigation of the need for intervention based on the extent of the problem and community demand, and the type of program that might best address that need (Cunningham & Baker, 2003). There can then be a search for an existing appropriate and applicable program. If no suitable program exists, a needs assessment can identify the necessity for developing a program.

B) Process Evaluation

The next step is a process evaluation where the implementation of the program is tracked along with the challenges of application and solutions to these challenges. Process evaluations also determine if the program is meeting the needs of the intended clients. This assessment often involves interviews with clients and other community agencies to obtain their feedback on the program and whether or not it is meeting their needs. These interviews can provide indications of where changes may be occurring for clients and potential problems that would impede change (Cunningham & Baker, 2003). Feedback from clients and the community can then be used to modify the program and/or its implementation. When this is done the evaluation becomes formative in nature. For this reason process evaluations are sometimes referred to as formative evaluations, particularly when they are used to formulate a new program rather than implement an existing one.

C) Outcome Evaluation

The final step is the outcome evaluation. Quality outcome evaluations require pre- and post-testing of program and control groups with well validated measures of behaviour and knowledge, random assignment to program and control conditions, large sample sizes, follow-up assessment, and the utilization of different sources of information. However, most studies attempting outcome evaluations of programs for children who live with violence have methodological and design problems that negate their capacity to

determine effectiveness (Graham-Berman, 2000). Among the most common problems are: a lack of control groups, self reports, small sample sizes, lack of randomization in groups, high rates of attrition at post-test, and a lack of follow-up. Currently there is no outcome evidence that any of the existing interventions are effective and most interventions are not tested (Cunningham & Baker, 2003). This clearly identifies the need for more rigorous evaluations of existing and developed programs.

i) Efficacy

Comprehensive outcome evaluations are comprised of three different components. The first component is the determination of the efficacy of the program. This is typically the component that is of most interest to agencies implementing programs. It assesses if the program has its desired effect on clients and whether clients improve in intended areas. This type of evaluation should only be conducted when the program has been well established and administered. Through the use of experimental methods, the degree of change and whether change is more significant than without the program can be determined. Efficacy evaluations should include an assessment of both positive and negative program outcomes. It cannot be assumed that program outcomes will always or only be positive.

Because efficacy evaluations help determine if the program is meeting its goals, these goals need to be realistic, clearly defined, and measurable. Program goals are usually related to reducing one or more symptoms, increasing knowledge, and changing attitudes that support violence. A common problem with outcome evaluations, is the citing of goals that are difficult or impossible to measure. For example, some might cite reducing violent or criminal behaviour as a goal. Assessing the achievement of that goal would require extensive and long-term follow-up with clients, something that is not always realistic given available resources (Cunningham & Baker, 2003). Alternately, some measures or instruments do not sufficiently assess achievement of program goals. Changes in behaviour are sometimes assessed by self reports of potential responses to hypothetical situations. In these cases children may over estimate their capacity to respond in a desirable way in a given situation. Behavioural changes can be observed directly or obtained through reports of individuals who interact with the child such as family and teachers. However, parents may over-estimate changes in their child's behaviour in order to support the program and justify the time and effort put into the program (Cunningham & Baker, 2003). Thus, a variety of methods are required to circumvent the biases in responding.

Besides attention to goal achievement, efficacy evaluations also have to work to eliminate alternate explanations of change at post-test. These might include natural changes that occur over time, life and experiential events, biases in the manner of answering evaluation questions, and the amount of time and emotional distance from the violence (Cunningham & Baker, 2003). Control groups and randomization help to address some of these possible confounds.

Generally it is suggested that agencies that deliver programs collect data on client satisfaction with the program, but that outcome evaluations require external evaluators to maintain the rigorous conditions necessary for quality and objective outcome results. However, the cost and logistical difficulty in conducting outcome evaluations in community settings make these evaluations infrequent and often inadequate (Cunningham & Baker, 2003). Some examples of evaluations that work towards meeting the criteria of a quality outcome evaluation can be found in Sullivan, Bybee & Allen (2002), Jouriles and colleagues (2001), and Graham-Bermann (2000).

ii) Effectiveness

The effectiveness component of outcome evaluation assesses if the program works with the same degree of efficacy for agencies and locations other than those where the program was first developed. This determination will help to validate the program as one that can be implemented in a variety of locations. This type of evaluation then, is important to program developers who are interested in marketing the program beyond their agency and agencies interested in delivering an existing program (Cunningham & Baker, 2003).

iii) Efficiency

The final component of outcome evaluation is to determine if the program is as efficient as other interventions. Efficiency can be defined in terms of cost and time. All things being equal, an efficient program produces the desired results in less time and with less money. However, some programs may cost more, but provide better results. Thus, indicators of efficiency must weigh out costs and benefits of programs. Organizations that fund program delivery interested in the efficiency of program application (Cunningham & Baker, 2003).

In summary, the following checklist for outcome evaluations is provided by Cunningham and Baker (2003):

- The agency should have a record of successful program implementation and a stable referral base.
- Clear criteria for program eligibility.
- A means of assessing potential program changes that could alter outcomes over time.
- Measurement of program dosage and reasons for drop out.
- A large sample (200 or more participants).
- Determination of group membership by random assignment.
- Use of multiple methods to assess change including a beahvioural measure of change that is measured in a nonbiased and objective way.
- Delivery of the program in multiple places for effectiveness evaluation.
- Another intervention to use as a comparison for efficiency evaluation.
- Evaluators that are independent of either the program developer or deliverer.

2. Reflective Practitioners and Agencies

Service providers and agencies may want to informally evaluate their services to ensure that they are providing services that are of benefit to their clients. This may involve consideration and/or discussion around the following issues:

- How effective/helpful are the services I am involved in delivering?
- What could we be doing differently?
- Are there new approaches we could apply?
- Have there been consistent questions, concerns or complaints by clients?

Some agencies will ask clients to complete a brief satisfaction form pertaining to the services they received. The issues relayed through these satisfaction forms can help service providers assess if and where changes may be needed.

IX: Appendices

Appendix A: Checklist for Screening Potential Service Providers

This checklist contains beneficial qualities and qualifications found in children's counsellors and the myths surrounding children's experience with violence in the home. This checklist could be used to assess potential employees appropriateness as a children's service provider. These qualities may be assessed through direct questions or through observation. Employers can also develop scenarios of typical and atypical events in the service provision with children affected by family violence and then ask the interviewee how they would handle these situations. Evidence of desired characteristics could then be determined through responses.

_____ An understanding of the rights of children.
_____ Use of appropriate language and/or a willingness to change inappropriate language.
_____ An understanding of the negative impact of corporal punishment.
_____ Likes children.
_____ Is flexible in thinking and intervention approaches considered.
_____ Is comfortable playing with children.
_____ An awareness of the effects of violence on children, parents and other family members.
_____ An awareness that children can become depressed and have suicidal thoughts and attempts.
_____ Knowledge of child development and the effect that violence has on that development.
_____ Has the capacity to be a good role model.
_____ Is a good listener.
_____ Is patient.
_____ Will put the child's needs first.
_____ Can be objective in their perspective.
_____ Has a clear sense of boundaries.
_____ Is aware of personal issues and biases and has or is dealing with them.
_____ Is able to talk about sensitive issues with children and parents.
_____ Has and employs good self care techniques.
_____ Knowledge of good parenting skills.
_____ Experience working in crisis situations.
_____ Good organizational skills.
_____ Knowledge of community resources.

Appendix B: Information to Consider Including in Assessment and Intake

Not listed in order of importance.

- Personal information
- Health information
  - emergency contacts
  - primary physician
- Family Context
  - housing
  - residential stability
  - household composition
  - educational background of family members
  - economic situation/employment of adults in the house
  - community supports for family (extended family, friends, neighbours, other)
  - marital status
  - if the family going through a divorce, what is the level of conflict,
  - history of involvement with justice system
  - additional family dynamics
  - maternal stress and impact on child rearing
  - role of religious practices or faith community in family life
  - cultural/ethnic background/country-of-origin of family members
  - sub-cultures (i.e. gay/lesbian, disabilities)
  - ethnic and cultural influences
  - family's strengths, coping skills, defences,
  - safety issues and safety planning
  - service needs in the family members words
- Child's Information
  - gender, age of child
  - school or day-care information
  - involvement of teachers or child care providers
  - resiliencies/strengths of child
  - types of violence the child has been exposed to
  - severity, duration and of violence witnessed
  - impact of shelter residence, if applicable
  - current level of functioning and developmental status
  - child's vulnerabilities
  - problems and/or parental concerns
  - abuse status
  - general sense of how the child has been affected by witnessing violence
- Informed consent

Appendix C: Supplies for Therapy with Children and Families

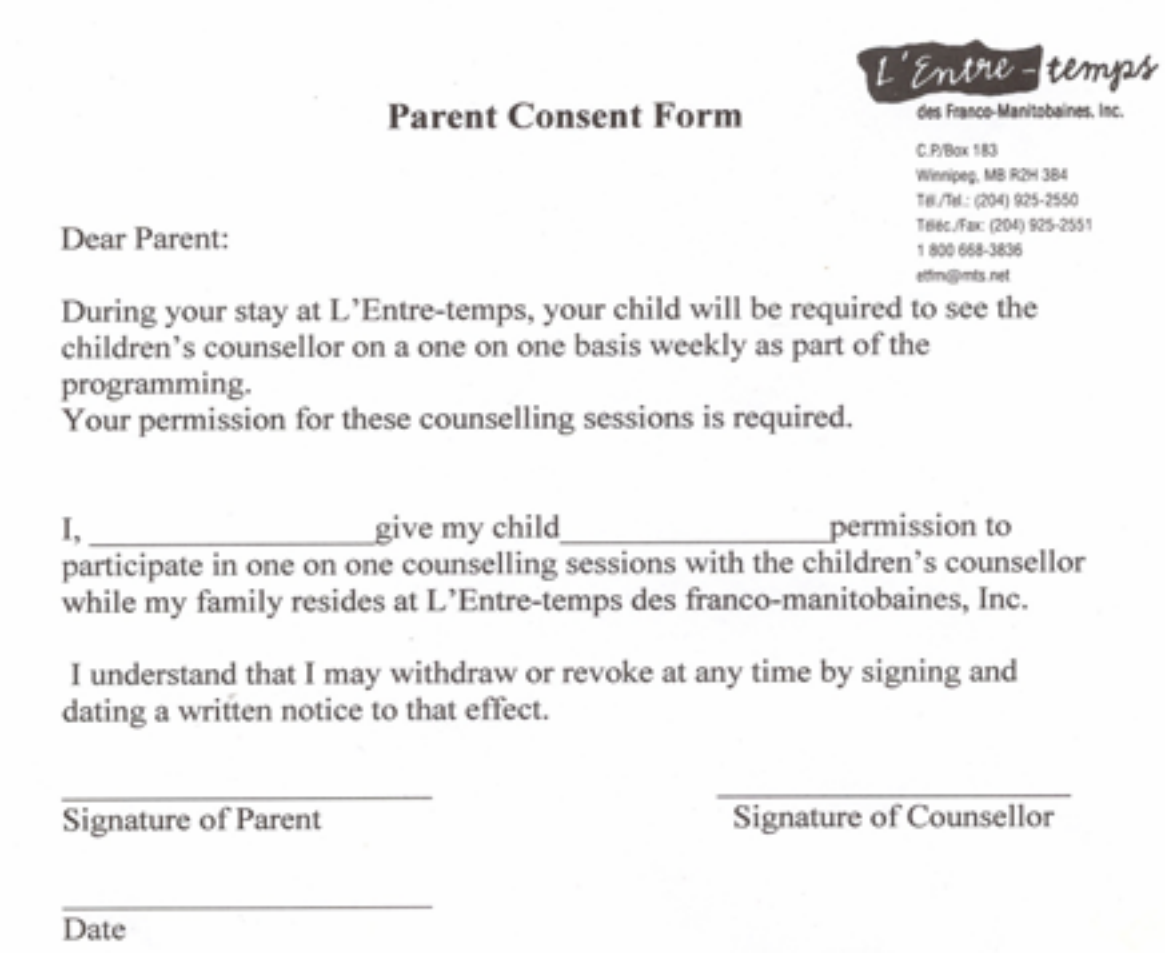
- Furniture and associated items
    - child's kitchen: toy stove, kitchen cupboard, sink, plastic cutlery/pots and pans
    - Child's table and chairs
    - Bean bags
- Toys
    - Doll house, furniture and family
    - Variety of dolls – Rag, baby
    - Doll bed, pram with pillow and sheets
    - Teddy bear
    - Doll clothes, bottle, diapers
    - Two toy phones
    - Mirror
    - Toy vehicles
    - Shopping basket
    - Empty food packets
    - Play money
- Equipment and materials
    - puppets
    - sand tray with miscellaneous small objects/toys
    - clay, play-doh, femo
    - paper
    - crayons, markers, paints, finger paints
    - cardboard boxes
    - spools
    - pipe cleaners
    - glue scissors
    - sticky tape
    - paper, coloured paper, artpaper and cardboard
    - wool
    - wooden spatulas
    - glitter
    - wooden blocks
    - smocks to protect clothing
- Miniature animals and figure
    - farm animals
    - zoo animals
    - assorted dinosaurs of different sizes
    - miniature figurines to include superheroes and other current characters
- Dress-up materials
    - a variety of clothes and materials for dressing up, including jewellery, wigs, swords and handbags
    - doctor's or nurse's set

    - assorted masks
    - mirror
- Books
    - story books
- Worksheets and workbooks – see recommended resources section
- Games
    - assorted games such as Jenga, Connect 4, playing cards and dominoes
- Miscellaneous prizes

From: Geldard & Geldard (2002) and committee members

Appendix D: Informed Consent Form Examples

A) Sample 1 from L'Entre-temps



L'Entre-temps
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Tél./Tel.: (204) 925-2550
Téléc./Fax: (204) 925-2551
1 800 668-3836
etfm@mts.net

Parent Consent Form

Dear Parent:

During your stay at L'Entre-temps, your child will be required to see the children's counsellor on a one on one basis weekly as part of the programming.
Your permission for these counselling sessions is required.

I, _____give my child_____permission to participate in one on one counselling sessions with the children's counsellor while my family resides at L'Entre-temps des franco-manitobaines, Inc.

I understand that I may withdraw or revoke at any time by signing and dating a written notice to that effect.

_____ _____
Signature of Parent Signature of Counsellor

_____
Date

L'ENTRE-TEMPS DES FRANCO-MANITOBAINES

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ , hereby authorize L'Entre-temps des franco-manitobaines staff to exchange information with

_____

_____

regarding myself, _____

regarding my child/children _____

_____

_____

_____

_____

_____ _____

Client's signature Date

_____

Witness

PARENT'S CONSENT FORM

Dear Parent:

During your stay here at l'Entre-temps, your child will have the opportunity to participate in activities off l'Entre-temps premises.

In order that your child may be included, a signed permission to participate is required.

If your child has your permission to participate in these field trips, please complete and sign the form below.

_____
Staff

I give my child _____permission to participate in _____ on _____, 199_____.

I authorize l'Entre-temps_____ and/or volunteer_____ to supervise my child during this activity. I believe the necessary precautions will be taken for the care and supervision of my child.

_____ _____
Signature of parent Signature of staff

Date _____

B) Sample 2 from University of North Texas

PARENTAL CONSENT FOR COUNSELING 2006-2007

Texas Academy of Mathematics and Science ♦ University of North Texas

In order to assist students in their adjustment at TAMS and to help them with emotional and/or personal problems that may develop, counseling services are available at no cost to the student or to his or her family. Dr. Donna Fleming, Academy Psychologist, is a licensed psychologist with a specialty in adolescent issues. She is assisted by a UNT graduate student in psychology. Both are available to meet with students for daytime or evening appointments.

Students will be informed about the counseling services during fall orientation and at their wing meetings. They will also receive a letter with the details of how to make an appointment. This information is also printed in the TAMS Student Handbook.

All records regarding a student's counseling are kept confidential and are not included with other student records.

If your son or daughter is under age 18, then we need your permission to provide psychological services or counseling. In some situations, including mental health emergencies, a signed permission form would *not* be required in order for us to render help. However, it is strongly recommended that you sign the attached form and return it so that professional help in non-emergency situations may be provided to the student.

PARENTAL CONSENT FORM

I agree to allow _____ to receive counseling services
(Student's Name)

from Dr. Donna Fleming or the TAMS counseling staff for the academic school

year of 2006-2007. I also agree to allow _____ to receive
(Student's Name)

counseling services from the UNT Counseling and Testing Office if Dr. Fleming

makes a referral to that facility. I understand that I may revoke this consent at

any time by signing and dating a written notice to that effect.

Parent/Guardian
Print Name _____

Parent/Guardian
Signature _____ Date _____

C) Sample 3 from Peled and Davis (1995)

PERMISSION TO TREAT MINORS FORM

(sample)

Permission to Treat Minors

(Fill out one form for each child)

I give the

_____

Agency name

permission to provide assessment and counseling services for my minor child.

_____

Child's name

Because

_____

Agency name

is identified as a helping professional, all employees are mandated reporters. Therefore, if a therapist knows or has reason to believe that my child has been or is being physically abused, sexually abused, or neglected, I understand that this information must be reported to Child Protection Services.

I also understand that the specific content of sessions between my child and his/her therapist will remain confidential and that my child has the right to request that information about his/her treatment not be shared with me.

(However, all information concerning danger to my child will be reported. General reports of my child's progress also may be made to me under this agreement.)

_____

Signature of parent with legal custody

_____

Date

D) Sample 4 from the Center for Ethical Practice

*** SAMPLE Adolescent Informed Consent Form**

Your Letterhead

Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of or would be upset by -- but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential-to not tell your parent or guardian-I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

[You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Minor's Signature _____ Date_____

Parent Signature _____ Date_____

Parent Signature _____ Date_____

***NOTE: This is a sample form, designed for training purposes.**
To the best of our knowledge, it is consistent with Virginia laws and regulations.
For use in your own setting, this form must be personalized
to reflect your state's laws and your own actual policies about confidentiality.

Drafted for The Center for Ethical Practice
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X: Recommended Sources

Bancroft, L. (2004). *When dad hurts mom: Helping your children heal the wounds of witnessing abuse.* New York: Berkley Books.

Berg, I.K. (1994). *Family-Based Services: A solution-focused approach.* New York: W.W. Norton & Company, Inc.
Describes Solution-Focused Therapy in detail, including various steps and techniques to guide the process.

Geldard, K. & Geldard, D. (2002). Counselling children: A practical introduction (2nd Ed). Great Britain: Sage Publications, Inc.

Piedt, S., Beggs, S. Healing families; Stopping violence: A program for parents and children who have experienced family violence. Edmonton, Alberta: Child and Adolescent Services Association.
A session-by-session manual detailing programming for children's groups, groups for their non-abusive parents, and family groups. Includes activities, group circle and video suggestions, check-in and check-out questions. Also includes staff preparation and planning information.

Peled, E. & Davis, D. (1995). Groupwork with children of battered women: A practitioner's manual. USA: Sage Publications, Inc.
A thorough, practical guide that includes a 10 session plans for groups with children and parents. Peled and Davis's approach is cited by others as an excellent model for this type of work. Includes: Intake and Assessment form templates; templates for interviewing children and parents; short stories appropriate for use with children.

Peled, E., Jaffe, P., Edleson, J. (Eds.) (1995). Ending the Cycle of Violence: Community Responses to Children of Battered Women. USA: Sage Publications, Inc.

- Bilinkoff, J. Empowering Battered women as mothers In *Ending the Cycle of violence*. Pg 97-105.
  Bilinkoff 's short chapter recommends a number of ways to empower women who are leaving violent situations. She addresses practical issues affecting their mothering and offers suggestions for ways of re-visioning her role as parent and the way the family system operates.
- Mathews, D.J , (1995). Parenting groups for Men who Batter. Pg. 106-20.
  Mathews offers a framework for working with this population. The article includes critical issues to be addressed and activities to work through them.

Sharry, J. (2004). Counselling children, adolescents and families. Great Britain: Sage Publications, Inc. Includes chapter on parenting groups

Pence, E. and Paymar, M. (1993). Education groups for men who batter: The Duluth model. New York: Springer Publishing Company.
Gives detailed description of the application of this model of groups for men who use violence. Includes program design, curriculum breakdown, facilitators guide and evaluation of domestic abuse intervention programs. Also includes stories, questions for discussion, activities, role plays, and other tools. Stresses keeping women's experiences of domestic violence at the centre of all programming. There has been some suggestion that this model (Duluth Model) is out of date, yet the emphasis on perpetrator accountability and challenging rigid gender biases with men who use violence are still considered to be valuable content for such a group (Hamel, 2005).

Sokoloff, N. J. Bibliographic References for Multicultural perspectives on domestic violence in the US. http://www.lib.jjay.cuny.edu/research/DomesticViolence/
Incredibly detailed bibliography of resources. Topics include: Multicultural domestic violence theories/approaches/analysis; specific racial/ethnic groups and domestic violence; Social class, socio-economic status, related issues, and domestic violence; religious groups and domestic violence; lesbians; social and personal change; Rural domestic violence; Disabled women and domestic violence; Elder abuse and domestic violence; Women who use violence against partners and women in prison for domestic violence.

Other recommended resources from the group:

- Books: The Elf books, Mercer Meyer, Franklin, the Magic Colouring book (Source Resource)
    - www.lianalowenstein.com
    - Prairie Sky books will order
    - Source Resource – publishing house for schools

Manitoba Family Services and Housing. Child protection and child abuse manual: A protocol for early childhood educators.
http://www.pacca.mb.ca/pdf/early_childhood_educators_protocol.pdf

Codes of Ethics:

- Canadian Professional Counsellors Association code of ethics
  http://www.cpca-rpc.ca/content/view/14/28/

- Canadian Psychological Association, code of ethics
  http://www.cpa.ca/cpasite/userfiles/Documents/Canadian%20Code%20of%20Ethics%20for%20Psycho.pdf

- Canadian Association of Social Workers Code of Ethics
  http://www.casw-acts.ca/practice/codeofethics_e.pdf

XI: Manitoba Agencies Offering Family Violence Programming for Children

Winnipeg
Alpha House
Elizabeth Hill Counselling Centre
Family Centre of Winnipeg
Fort Garry Women's Resource Centre
Ikwe Widdjiitiwin
Klinic Community Health Centre
L'Entre Temps des Franco Manitobaines
Ma Mawi Wi Chi Itata Family Violence Program
Manitoba Adolescent Treatment Centre
Native Women's Transition Centre
New Directions for Children, Youth, Adults and Families
Nor-West Co-op Community Health Centre
Osborne House
Winnipeg Children's Access Agency
Women in Second Stage Housing (WISH)
Wolseley Family Place

Brandon
Westman Women's Shelter

The Pas and Area
Aurora House (The Pas)
Women's Safe Haven Resource Centre (Flin Flon)
Snow Lake Family Resource Centre

Dauphin and Area
Parkland Crisis Centre
Swan Valley Crisis Centre

Selkirk and Area
Interlake Women's Resource Centre (Gimli)
Lakeshore Women's Resource Centre (Ashern)
Nova House (Selkirk)

Steinback
Eastman Crisis centre (Agape House)

Portage La Prairie
Portage Women's Shelter

Thompson
Thompson Crisis Centre

XII: References

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This literature review on child exposure to domestic violence is integrated with clinical experience to create a new framework for understanding, studying, and intervening with children who have lived with woman abuse. Case studies are presented.

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Program Manuals

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This manual provides a step by step guide for leaders providing groups for children and their parents who have been traumatized by family violence.

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This program has 16 therapeutic sessions that can be presented to children as young as two in either open or closed sessions.

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This program provides a supportive arena for children ages 6 to 13 to share their experiences, to learn that they are not alone, to identify sources of worry and concern, to discuss conflict and its resolution, to explore issues of responsibility for violence, and to learn new strategies for coping and problems solving.

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This group intervention for children aged 3 to 6, who were exposed to violence, encourages children to share their ideas about their feelings, ways of coping, thoughts about family, ethnicity and the future.

Groves, E., Roberts, E., & Weinreb, M. (2000). *Shelter from the storm: clinical intervention with children affected by domestic violence.* Boston, MA: Child Witness to Violence Project, Boston Medical Centre [236 pages].
This training manual for mental health providers includes workshop materials for 13 hours of training, slides, complete bibliography, and reproducible handouts.

Loosley, S. & Contributors. (1997). *Group treatment for children who witness woman abuse: A manual for practitioners.* London, ON: Children's Aid Society of London and Middlesex [175 pages].
This 10 session group is designed for ages 4 to 16 with 5 separate age groups recommended.

Malchiodi, C (1997). *Breaking the silence: Art therapy with children from violent homes, 2nd Edition.* Philadephia, PA: Brunner/Routledge [208 pages].
Emphasis is given to the short term setting where time is at a premium and circumstances are unpredictable.

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Peled, E. & Davis, D. (1995). *Groupwork with children of battered women: A practitioner's manual.* Thousand Oaks, CA: Sage Publications.
With excellent detail and hands-on style, this manual provides practitioners with the required knowledge and direction to successfully operate a group program for 4 to 12 year old children of battered women.

Red Flag Green Flag Resources. (2002). *I wish the hitting would stop curriculum.* Fargo, ND: RFGF Resources.
This curriculum is written to educate all children in a classroom about the issues of domestic violence, regardless of whether or not there is violence in their homes.

Roseby, V. & Johnson, J.R. (1997). *High-conflict, violent, and separating families: A group treatment manual for school-age children.* New York: Free Press [60 pages].
This manual covers ten sessions including exploring levels of feelings and coping with fighting families.

Wilder Community Assistance Program. (1997). *Children's domestic abuse program, group manual.* St. Paul, MN: Amherst H. Wilder Foundation [438 pages].
This program is designed to support counselors, therapists, caseworkers, and educators who work with child victims of domestic violence in group session.

Wright, L. (1991). *I love my dad but….* Toronto, ON: Is Five Press [38 pages].

This simply written and illustrated book deals with the complicated, painful problem of an abusive parent in a sensitive, direct and practical manner. The exercises for children are gentle and non-intrusive, yet helpful to therapists assisting children explore their families and their resources in an abusive situation.

Resource Books and Training Materials

Baker, L & Cunningham, A. (2004). *Helping children thrive: Supporting woman abuse survivors as mothers: A resource by support parenting.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic. www.lfcc.on.ca/mothers.html.

This resource is written for serviced providers assisting women who have survived woman abuse. Material addresses the needs of abused women as mothers, how abusive men parent and how they affect family dynamics, effects of power and control tactics on mothers, the potential impact of woman abuse on children of different ages and strategies used by children to cope with abuse in the home. Available in French or English; 76 pages.

Baker, L. & Cunningham, A. (2004). *Youth exposed to domestic violence: A handbook for the juvenile justice system to enhance assessment and intervention strategies for youth from violent homes.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

This handbook provides information to help better understand the needs of children who grew up in violent homes. They may be victims of violence, witnesses to violence, perpetrators of violence, or involved in abusive relationships; 30 pages.

Baker, L. & Cunningham, A. (2005). *Learning to listen, learning to help: Understanding woman abuse and its effects on children.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic. www.lfcc.on.ca/learning.html.

A resource designed for students (and volunteers) in the helping professions to prepare them to recognize and respond to families in which there is or was violence in the home. Available in French or English; 33 pages.

Baker, L. & Cunningham, A. (2005). *Professor's resource guide to teaching about woman abuse and its effects on children.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

A teaching aid for the professor who is planning a lecture or workshop on how woman abuse effects infants, children or teenagers. Background resource material is provided that can help in lecture preparation. Available in French or English.

Baker, L. & Cunningham, A. (2005). *Through a new lens / seeing woman abuse in the life of a young child: A learning module for early childhood education programs.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

This resource presents everything needed by teachers of early childhood educators to plan a two-hour lecture or a full day workshop. All materials and resources are included in this CD based resource. Available in French or English.

Baker, L., Jaffe, P., Ashbourne, L.M. & Carter, J. (2002). *Children exposed to domestic violence: A teacher's handbook to increase understanding and improve community responses.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

This resource helps educators understand how violence affects children at different ages, what teachers may see in the classroom, recognizing the signs students may display when they are having difficulties, teach strategies to support children and supporting children who disclose; 26 pages.

Baker, L., Jaffe, P & Ashbourne, L. (2002). *Children exposed to domestic violence: An early childhood educator's handbook to increase understanding and improve community responses.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

A concise summary of key information relevant for front-line staff in child care and early childhood educational settings. It includes a pamphlet for parents, in both English and Spanish.

Baker, L., Jaffe, P., Berkowitz, S.J. & Berkman, M. (2002). *Children exposed to violence: A handbook for police trainers to increase understanding and improve community responses.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

A train the trainer manual. Topics addressed include understanding the neds of children, risk reduction and safety planning, and issues related to dual arrest.

Baker, L., Jaffe, P. & Moore, K. (2001). *Understanding the effects of domestic violence: A trainer's manual for early childhood educators.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

A comprehensive train the trainer package including background explanatory material, warm-up exercises, suggested activities and case studies. Available in French and English; 110 pages.

Baker, L., Jaffe, P. & Moore, K. (2001). *Understanding the effects of domestic violence: A handbook for early childhood educators.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.

This handbook is designed specifically for the early childhood education field. In one user friendly source, ECE students and practitioners learn the most relevant information required to identify and assist children who have been exposed to adult domestic violence. Available in French and English; 18 pages.

Centre for children and Families in the Justice System. (2004). *Handbook for police responding to domestic violence.* London, ON: London Family Violence Court Clinic. www.lfcc.ca/handbook_police.html.

This trainers manual discusses domestic violence related issues from the police perspective including issues related to dual arrest and recognizing the presence of children on the scene; 32 pages.

Davis, D. (1996). *Something is wrong at my house*. Seattle, WA: Parenting Press, Inc.
Story for children exposed to family violence.

Heegaard, M. (1993). *When a family is in trouble*. Minneapolis, MN: Woodland Press.
Story for children exposed to family violence.

Jaffe, P, Baker, L. & Cunningham, A. (2004). *Protecting children from domestic violence.* New York: Guilford Press.
The 14 chapters of this book introduce the problem and address individual and group level responses as well as system level responses.

Jaffe, P., Lemon, N. & Poisson, S. (2003). *Child custody & domestic violence: A call for accountability.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.
This book brings together recent clinical and legal issues in the field from North America and elsewhere in considering the prevalence of divorce and domestic violence as well as the relevance of domestic violence in custody disputes; 194 pages.

Jaffe, P., Russell, M. & Smith, M.J. (2000). *Creating a legacy of hope: Proceedings of an international conference on children exposed to domestic violence.*
Vancouver, BC: B.C./Yukon Society of Transition Houses.
www.lfcc.on.ca/legacyofhope.html.
Twenty three papers are included on a variety of topics including child witnesses in immigrant families, the link between animal abuse and domestic violence, and the experience of several intervention programs.

Jaffe, P., Zerwer, M. & Poisson, S. (2002). *Access denied: The barriers of violence and poverty for abused women and their children's search for justice and community services after separation.* London, ON: Centre for Children and Families in the Justice System, London Family Violence Court Clinic.
Presented are the results of a two year study in which 62 women and 95 of their children were interviewed about their experiences after separation from an abusive partner. Each section of the report contrasts the myths and facts juxtaposed with study facts and recommendations.

Paris, S. (1998). *Mommy and daddy are fighting*. Seattle, WA: The Seal Press.
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Perry, L. & Sutherland, P. (2003). *It's not my fault!* Winnipeg, MB: Elizabeth Hill Counselling Centre.
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Winn, M.C. with Walsh, D. (1996). *Clover's secret*. Minneapolis, MN: Fairview Press. Story for children exposed to family violence.