HELPING OUR CHILDREN: A SUPPORT GROUP FOR CHILDREN OF DOMESTIC VIOLENCE

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By

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Abstract

HELPING OUR CHILDREN: A SUPPORT GROUP FOR CHILDREN OF DOMESTIC VIOLENCE

By

Zuneybi Contreras

Master of Science in Counseling, Marriage and Family Therapy

Every year, an estimated 3.3 million to 10 million children are exposed to domestic violence in their homes (Herrenkohl et al, 2010). Research demonstrates that children who have been exposed to domestic violence may experience various emotional, behavioral, physiological, and social reactions to having witnessed the traumatic events. Witnessing domestic violence may result in anger, withdrawal, or feelings of self-blame. Children may have trouble sleeping, focusing in school, and failure to thrive. In addition, children who have witnessed domestic violence may experience difficulties forming or maintaining relationships. While children who witness domestic violence can be seen in individual therapy, participation in a support group may normalize the emotions they may be feeling, may help children establish and maintain friendships, and provide healthy coping strategies as well as anger management techniques. Strength United, a clinical training site that provides individual and group therapy may use this curriculum when providing treatment to children who have been exposed to violence. The following curriculum is composed of nineteen interventions. The group is divided into ten one and a half hour sessions that meet weekly.
Chapter 1

Introduction

Domestic Violence (DV), also known as intimate partner violence, is a violent crime that affects not only the survivor, but the children who are involved or witness the domestic violence. According to Black, Sussman, and Unger (2010), DV is a “repeated pattern of physical, psychological, and/or sexual abuse against an intimate partner to gain control and compliance over a victim through fear tactics” (p. 1023). Children are increasingly being exposed to emotional, physical, and psychological domestic violence between intimate partners. Every year, an estimated 3.3 million to 10 million children are exposed to domestic violence in their homes (Herrenkohl et al., 2010). Thompson and Trice-Black (2012) state that “children who reside in homes marked by DV are exposed to various forms of aggression which may include repeated physical assaults, mental humiliation and degradation, threats and assaults with guns and knives, threats of suicide and homicide, and destruction of property” (p. 233). According to Tiaden and Thoennes (2000), up to 4.8 million women a year are victims of partner related assaults and rapes at the hands of their partner and up to 2.9 million men experience physical assaults by their partners. Thornton (2014) states that between 25%-30% of women experience domestic violence over their lifetime. The onset of the abuse, according to Thornton, is often at the time of pregnancy, birth, or when children are small. Parents may attempt to limit a child’s exposure to DV, however it is not uncommon for children to witness the violence that is occurring in their own household.

According to Bybee, Greeson, Kennedy and Sullivan (2010), a 2009 Bureau of Justice study revealed that just over one third of DV cases occurring in urban counties
occurred in front of the children and these were not isolated events, but ongoing conflicts. Barker, Borrego, Gutow and Reicher (2008) postulate that battered women and their children experience significant negative consequences as a result of the domestic violence. Thornton (2014) contends that children living in DV households have up to four times a higher rate of pathology than those from nonviolent homes. Process groups are available for women who have experienced DV, but for the emotional wellbeing of the children, process groups need to be made available to them as well. The availability of process groups will help prevent pathology and will help children process the violence they have witnessed.

Many children who witness domestic violence are also diagnosed as being maltreated. Barker et al. (2008) report that child physical abuse and other forms of child maltreatment occur in 30-70% of domestic violence cases. According to Thornton (2014), children either witness the abuse firsthand, or are in the other room when the abuse is taking place and later see the bruises. In a study of 246 children living with mothers who had been physically assaulted by their partners, Abrahams (1994) found that 73% of children have witnessed the assaults firsthand and 52% has witnessed the resulting injuries (Abrahams, 1994). Beran, Poole, and Thurston (2008) state that the majority of women who are entering battered women’s shelters bring children with them. Thornton (2014) states that the belief that children are unaware of what is occurring in their homes has long been replaced by the recognition that children are aware of not only the violent incidents themselves, but the aftermath of the domestic violence as well. Exposure to DV is common, and has many adverse effects on children that should be addressed.
Statement of Need

Given the prevalence of children who witness domestic violence, it is imperative that mental health counselors be prepared with interventions to utilize when working with this population. Many mental health facilities offer psychoeducation/support groups for survivors of domestic violence, but there are little to no groups for the children who have been exposed to domestic violence. Strength United (SU-formerly known as Valley Trauma Center, 2016) is a clinical training site providing services to survivors of Domestic Violence, Sexual Assault, and to children who have been exposed to violence. Strength United is one of the stated agencies that provide individual and group counseling for survivors of Domestic Violence, however while individual counseling is available to children who have been exposed to violence, there is no group available so that children feel supported and know they are not alone.

Strength United has “Child Enrichment Groups”, which provide childcare and at times therapeutic activities for children while the parents are in their own parenting or domestic violence support group. This time could also be used to provide psychoeducation and support to the children who were also affected by the violence. Many parents bring their child in due to lack of child care and this time could more be used more efficiently by implementing the group curriculum during the time childcare is being provided. The importance of the group lies in the need for counselors to have a structured curriculum appropriate for children. Having a manualized treatment plan increases the quality and consistency of treatment. It also makes it so that the counselors do not need to look for interventions they can utilize in a group setting and research the validity of such interventions (Strength United, 2016).
Statement of Purpose

The purpose of this project is to construct a group curriculum for children who have witnessed domestic violence. The group curriculum can be used in any agency that provides mental health services to children and families. The project will consist of interventions that focus on providing psychoeducation on domestic violence and aiding children in exploring and expressing emotions associated with the violence. The group also aims at assisting them in developing coping skills.

Significance

The project will provide a structured group curriculum that Strength United and other agencies interested in providing support groups for children may utilize. The interventions recommended in this curriculum will be used by Marriage and Family Therapist trainees and interns to provide appropriate psychoeducation about domestic violence to children. Since Strength United is a training facility, the therapist trainees and interns will need to seek out weekly supervision to ensure the proper utilization of the curriculum.

Terminology

**Children:** Boys and girls ages 9-12 years old

**Domestic violence (DV):** A repeated pattern of physical, psychological, and/or sexual abuse against an intimate partner to gain control and compliance over a victim through fear tactics (Black, Sussman, & Unger, 2010).

**Physical abuse:** Any intentional and unwanted contact with the individual. Examples of physical abuse include scratching, punching, biting, strangling, kicking, throwing something at the individual and so on (loveisrespect.org, 2013).
**Psychological abuse:** Involves trauma to the victim caused by verbal abuse, acts, threats of acts, coercive tactics or gas-lighting. This type of abuse is used to control, terrorize, and denigrate the victim (National Coalition Against Domestic Violence, 2015).

**Emotional abuse:** Includes non-physical behaviors such as threats, insults, constant monitoring or “checking in”, excessive texting, humiliation, intimidation, isolation, or stalking (Loveisrespect.org, 2013).

**Economic abuse:** Implies the withholding of economic support and keeping tight control over the family’s economic resources, such as money and transport (Slabbert & Green, 2013).

**Posttraumatic Stress Disorder (PTSD):** According to *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed; DSM-5; American Psychiatric Association, 2013), symptoms such as avoidance, distressing memories of the events, avoidance of distressing memories, and outbursts of anger due to a history of exposure to a traumatic event (Diagnostic and Statistical Manual for Mental Disorders (APA, 2013).

**TF-CBT:** an evidence-based treatment approach shown to help children and adolescents overcome trauma related difficulties such as experiencing domestic violence and child abuse. This approach encourages children to face negative or distorted beliefs by providing a safe and supportive environment where children are encouraged to talk about their experiences (Child Welfare Information Gateway, 2012).

**Psychoeducation:** An intervention which provides information, education materials or feedback/advice offered through leaflets, posters, audio-visual aids, lectures, internet material or software (Donker, Griffiths, Cuijpers, and Christensen, 2009).

**Safety Skills/ Safety Plan:** Bringing to awareness unsafe or potentially unsafe situations
that the family may not be acknowledging. Early and ongoing validation of legitimate safety concerns. Safety planning is best when done collaboratively (Murray, Cohen, & Mannarino, 2013).

**Gaslighting:** an extremely effective form of emotional abuse that causes a victim to question their own feelings, instincts, and sanity, which gives the abusive partner a lot of power (National Domestic Violence Hotline, 2016).

**Witness:** witnessing can mean seeing actual incidents of physical and/or sexual abuse or hearing threats or fighting noises from another room. It also includes observing the aftermath of physical abuse such as blood, bruises, tears, torn clothing, and broken items (Domestic Violence Roundtable (2008).

**In-Vivo Exposure:** “Gradually or incrementally having contact with something feared in life by clients that is associated with the trauma” (Rubin et al. 2011, p. 124).

**Exposure:** Clients are encouraged to approach increasingly detailed and distressing trauma-related reminders and memories (Cohen, Murray, & Mannarino, 2013)

**Parent-Child Interaction Therapy (PCIT):** “An evidenced-based, parent focused, behavioral intervention for disruptive problems in young children between the ages of 2 to 7 years” (Barker, Borrego, Gutow, and Reicher, 2008, p. 497).

**Summary**

In order to better understand the need for workshops for children, it is necessary to review previous research demonstrating the negative effects exposure to domestic violence has on children at a young age and as adults. The following chapter will cover the effects of domestic violence on children and provide a review of literature examining the effectiveness of interventions.
Chapter 2
Review of the Literature

This chapter contains an overview of the types of domestic violence children witness and the effects exposure to domestic violence has on children. Trauma Focused-Cognitive Behavioral Therapy and Narrative therapy are also introduced.

Types of Domestic Violence

Physical abuse. According to Love is Respect.org (2013), physical abuse is any intentional and unwanted physical contact. The Center for Relationship Abuse Awareness (2015) provides examples of physical abuse that include pushing, biting, slapping, kicking, strangling, throwing objects, pulling hair, keeping an individual from seeking medical attention, using or threatening to use a weapon, animal cruelty towards family pets, stalking, and so on. The National Coalition Against Domestic Violence (NCADV, 2015) postulates that an average of 20 people per minute are physically abused by their partner in the United States alone. In one year, this amounts to more than 10 million men and women. According to the Domestic Violence Roundtable (2008), children witnessing domestic violence can mean seeing actual incidents of physical/or sexual abuse or observing the aftermath of physical abuse such as blood, bruises, tears, torn clothing, and broken items.

Psychological abuse. The NCADV (2015) defines psychological abuse as trauma to the victim caused by verbal abuse, acts, threats of acts, or coercive tactics. The coalition states perpetrators use psychological abuse to control or terrorize their victims. Psychological abuse typically occurs prior to or concurrently with physical or sexual abuse. According to the NCADV (2015), psychological abuse includes withholding
information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends of family, and undermining the victim’s confidence and/or sense of self-worth. Gaslighting is a common form of psychological abuse. The National Domestic Violence Hotline (2016) states that gaslighting is a form of emotional abuse that causes a victim to question their sanity, feelings, instincts and judgment. This gives the abuser a lot of power. Victims of gaslighting often second-guess themselves, feel confused, are always apologizing to their partner, and feel hopeless and joyless. Once the perpetrator has successfully broken down their partner’s ability to trust themselves, the victim is more likely to remain in the abusive relationship (National Domestic Violence Hotline, 2016). The NCADV (2015) states that a number of studies have found psychological abuse to increase the trauma of physical and sexual abuse. Studies have also demonstrated that psychological abuse alone can cause long-term damage to a victim’s mental health.

Emotional abuse. Love is Respect.org (2013) defines emotional abuse as “non-physical behaviors such as threats, insults, constant monitoring or ‘checking in’, excessive texting, humiliation, intimidation, isolation, or stalking” (para. 2). Slabbert and Green (2013) state emotional abuse is persistent, corrosive, and destroys self-worth and self-esteem. This type of abuse usually includes the use of ridicule, insults, accusations, infidelity, and ignoring the victim. Emotional abuse also includes isolation from their family, friends, and neighbors. According to these researchers, other authors are of the opinion that emotional abuse is more frequent than physical abuse and more difficult to detect, but emotional abuse is equally as destructive as physical abuse (Slabbert and Green, 2013).
**Sexual abuse.** Sexual abuse occurs when the perpetrator demands sexual activity without the victim’s consent. It is also referred to as marital rape whereby the male assumes that it is his right and privilege to have sex whenever he wishes and in any form he desires, without taking his partner’s feelings into consideration (Slabbert & Green, 2013). Love is Respect.org (2013) includes sexual abuse as any behavior that impacts an individual’s ability to control their sexual activity including, but not limited to, oral sex, rape, or restricting access to birth control.

**Economic abuse.** Slabbert & Green (2013) define economic abuse as withholding of economic support and keeping tight control over the family’s economic resources. The authors state that some abused victims do not have control of their money, as their partners control all finances. According to Love is Respect.org (2013), some signs of economic abuse are giving the victim an allowance and closely monitoring what is purchased, placing the victim’s paycheck into the abuser’s account and denying the victim access to it, forbidding the victim to work or limiting the amount of time the victim can work, and getting the victim fired or harassing them at work. The NCADV (2015) contends that in economic abuse, the abuser isolates the victim financially by separating the victim from their resources. Isolating the victim strips them from their rights and choices, creating a forced dependency on the abuser.

**Prevalence of Children Exposed to Domestic Violence**

According to Herrenkohl et al. (2010), every year, an estimated 3.3 million to 10 million children are exposed to domestic violence in their homes. These researchers state that children who have been exposed to domestic violence and/or child abuse in their homes are more likely to experience adverse psychological and behavioral outcomes. The
NCADV (2015) states that one in fifteen children are exposed to intimate partner violence each year and of those children, 90% are eyewitnesses to the violence. According to the Domestic Violence Roundtable (2008), “witnessing can mean seeing actual incidents of physical and/or sexual abuse. It can mean hearing threats or fighting noises from another room, [or] observing the aftermath of physical abuse such as blood, bruises, tears, torn clothing, and broken items” (para. 2). It also includes the fact that children may be aware of the tension in the home such as their mother's fearfulness when the perpetrator arrives home (Domestic Violence Roundtable, 2008).

**Exposure to Domestic Violence and PTSD**

The DSM-5 provides a set of criteria that needs to be met in order for an individual to be diagnosed as suffering from PTSD (American Psychiatric Association [APA], 2013). The following are some of the criteria that applies to adults, adolescents, and children ages 6 and older. Note that this is not the full criteria needed to be diagnosed with PTSD, but rather some of the symptoms experienced by victims.

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Recurrent, involuntary, and distressing memories of the traumatic event(s)
4. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
5. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic events.
6. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world

According to Margolin & Vickerman (2011), exposure to interpersonal violence is now recognized as a potential antecedent to posttraumatic stress disorder (PTSD) in youth. The authors state that emotional abuse, while often overlooked, is a potential precipitant or exacerbating factor of childhood trauma because it co-occurs with many forms of violence exposure. The authors state that several studies reported that between 13% to 50% of youth that have been exposed to domestic violence between parents meet the criteria for a diagnosis of PTSD (Margolin & Vickerman, 2011). In a sample of community children exposed to domestic violence conducted by Graham-Bermann and Levendosky (1998), only 13% of the children met diagnostic criteria for PTSD, however over 50% of the children met the symptom criteria for intrusive thoughts regarding the events, one-fifth of the sample exhibited avoidance of trauma related stimuli, and two-fifths of the sample experiences over-arousal symptoms as related to the events.

Graham-Bermann & Hughes (2008) use trauma theory to offer an explanation for behaviors not necessarily predicted by other theories. According to the authors, the child’s perception of the danger of the event and his or her estimation of protection from harm either for self or others, the meaning of the event to the child, and the immediate response of caretakers also influence the degree of trauma which the child may experience. The authors postulates that others have claimed that the trauma itself is not what causes individuals to become emotionally ill, but rather the inability to express trauma (Graham-Bermann & Hughes, 2008). Margolin & Vickerman (2011) state that as with all traumatic events, only a portion of the children exposed to domestic violence will develop PTSD. According to Thompson and Trice-Black (2012), young children exposed
to DV are at greater risk of developing Posttraumatic Stress Disorder (PTSD), which may increase developmental problems related to exposure to domestic violence.

**Effects of Domestic Violence on Child Development**

Beran et al. (2009) contend that the effect of domestic violence varies on the child’s developmental stage. According to the North Carolina Coalition Against Domestic Violence (NCCADV, 2016), children exposed to domestic violence experience different symptoms depending on their age group. The site posits that newborn children until age five suffer from sleep and/or eating disruptions, withdrawal or lack of responsiveness, intense pronounced separation anxiety, inconsolable crying, developmental regression, loss of acquired skills, intense anxiety, and increased aggression or impulsive behavior. Children ages 6-11 suffer from nightmares or sleep disturbances, aggression and difficulty in peer relationships in school, difficulty concentrating and difficulty with task completion, withdrawal or emotional numbing, and school avoidance. Children aged 12-18 can experience antisocial behavior, school failure, impulsive and/or reckless behavior, depression, anxiety, and withdrawal (NCCADV, 2016).

Thornton (2014) points out that young children who live in domestic violence households are especially disempowered because of limited verbal skills and the ability to express their emotions. Their developmental stage leaves them less able to verbally convey their experiences because traumatic events are commonly stored in affective memory, which makes them less accessible for verbal recall. Beran et al. (2008) state that preschoolers are in particular need of developing a sense of security and are at a greater risk for psychological maladjustments. Additionally, “children’s symptoms may include
difficulty with sleeping and eating, family and peer relationships, attention, academic performance, depression, anxiety, aggression, low self-esteem, posttraumatic stress disorder symptoms, and impaired physical health” (Israel & Stover, 2009, p. 1756).

**Exposure to DV and Effects on the Brain**

Perry and Chamberlain (2008) content that repeated trauma negatively impacts brain development. Perry (1999), states that fear involves a tremendous mobilization and activation of systems distributed throughout the brain. “Terror involves cortical, limbic, midbrain, and brainstem-based neurophysiology. Because the neuronal systems alter themselves in a ‘use-dependent’ way in response to patterned, repetitive neuronal activation, a state of terror will result…resulting in a set of ‘memories’” (para. 16).

Children, specifically young children, form memories of fear, which affects their functioning later in life.

Perry and Chamberlain (2008) state that the mind creates a blueprint of every new experience had and it is these experiences that are the building blocks of an individual’s life. Contrary to popular belief, the younger the child is, the more sponge-like the brain is, making it more vulnerable to trauma than for older children. Exposure to DV is about living in a frightening and threatening environment because even if the fights do not escalate and turn physical, the possibility is there and children live in constant fear (Perry & Chamberlain, 2008).

Perry and Chamberlain (2008) assert that the brain develops from the bottom to the top and from inside out. The normal development of the inside of the brain, according to the researchers, depends on the normal and healthy development of the lower parts of the brain. The top of the brain is where thinking occurs, and it is also the easiest to
modify. However, the researchers report that if a child has experienced trauma and threat, the lower parts of the brain will be impacted and they are harder to change as they’re older. Children exposed to violence are experiencing a state of fear during violent episodes or arguing. When the children are in a state of fear, the systems in the brain that are involved literally shut down and the brain development of these children is affected (2008). The positive being that individuals have the ability to add new neurons to the brain and just as skin, it can heal itself in the cortex, which is the most important area, and individuals can heal themselves and do better (Perry & Chamberlain, 2008).

Children who witness domestic violence may suffer from a short attention span, which may result in poor school performance and attendance. According to Perry (1999), when the child lives in constant fear, it is difficult to teach them because they are in persisting state of arousal and anxiety- or dissociated. The child is essentially unavailable to efficiently process the complex cognitive information being conveyed by the teacher. Perry states that “the capacity to internalize new verbal cognitive information depends upon having portions of the frontal and related cortical areas being activated—which, in turn, requires a state of attentive calm. A state the traumatized child rarely achieves” (para, 36).

**Emotional Effects of Exposure to DV**

Aside from the developmental effects witnessing DV can have on children, they often suffer from emotional distress when exposed to household violence. Children who witness DV often experience chaotic, distressing events. They have little to no control and have difficulty understanding the hostility between the partners (Thompson & Trice-Black, 2012). According to Campell and Lewandowskli (1997), expressions of hostility
between partners are oftentimes followed by expressions of love, which confuses the child. Thompson and Trice-Black (2012) conclude that this back and forth cycle inhibits the child’s ability to trust, develop a sense of personal control, and develop a sense of safety and security in the world. Rossman and Ho (2000), describe children’s experience with serious forms of domestic violence as a type of war zone in which sometimes children can predict the violence that is to come, but other times it is unexpected, leaving the child with a sense of danger and uncertainty. Graham-Bermann and Hughes (1998), state that children who are exposed to domestic violence experience a wide range of reactions and have different symptomologies, if any at all. Some children are overwhelmed with fear, shame and anger, while others appear to be unaffected by the exposure to domestic violence and show little to no symptoms affiliated with exposure to trauma.

Children exposed to DV show diminished empathy, interpersonal sensitivity, and appropriate interpersonal skills (Thompson & Trice-Black, 2012). Fantuzzo and Mohr (1999) indicate that children witnessing DV also have feelings of self-blame and exposure to DV has been linked to increased risks for suicidal ideation and behaviors, phobias, and decreased self-image and self-esteem. According to Barker et al. (2008), one of the most common effects is traumatization, which is characterized through distress symptoms including excessive crying, sleep disturbance, fear, argumentativeness, and nightmares. Thornton (2014) notes that children living in domestic violence households report feeling isolated and ignored. They express difficulty sharing their concerns due to fear of not being believed and poor peer relationships. These children have reported feelings of helplessness, frustration, guilt, shame, and confusion.
Behavioral Effects of Exposure to DV

Black, Susman, and Unger (2010) believe that since the family is a main source of childhood learning, aggression modeled between two parents teaches children that violence is an effective means of conflict resolution or a means of gaining control, resulting in children acting out against others. Barker et al. (2008) contend that child witnesses have increased levels of aggression, anger, defiance towards parents, and social skill impairment. Graham-Bermann and Hughes (2008) contend that when domestic violence occurs in the home, children are exposed to behaviors meant to subdue and control the woman. These behaviors are conveyed to the child in multiple ways including direct modeling and through reinforcement. Due to the exposure to these behaviors, the child may learn aggression tactics, learn to manipulate, to cajole, and to coerce others with the purpose of having their needs met. The effects of exposure continue into adolescence and adulthood. Thompson and Trice-Black (2010) state that adolescents who have been exposed to domestic violence frequently lead to problematic behaviors such as substance abuse, aggressive and antisocial behaviors, interpersonal problems in school, and decreased academic functioning. Furthermore, adolescents who were abused as children are more likely to exhibit behaviors such as delinquency and violence perpetration (Herrenkohl et al., 2010). Adults who were exposed to DV as children also exhibit increased risks of engaging in violent behavior, criminal activity, and poor parenting practices (Margolin & Gordis, 2000). According to Graham-Bermann & Hughes (1998), studies reveal that children who live in domestic violence households have lower self-esteem, more depression, and more difficulty paying attention in school.
These children also have higher levels of both internalizing and externalizing behaviors than those children who are raised in nonviolent families.

**Physiological Effects of Exposure to DV**

According to Perry and Chamberlain (2008), Childhood DV exposure has been linked to higher rates of physical health problems in children. Children exposed to DV experience physical symptoms such as trouble sleeping, and failure to thrive (Thornton, 2014). Due to violence being an ongoing threat to children, many are forced to be constantly alert and hyper-vigilant (Epstein & Keep, 1995). According to Fantuzzo and Mohr (1999), children exposed to DV may externalize their emotional problems behaviorally and exhibit problems such as reduced impulse control and temper tantrums. Thompson and Trice-Black (2012) also reported that physiological responses to repeated exposure to domestic violence elevate the stress feedback system in the brain and heighten the child’s perception of danger. The heightened awareness may be evidenced by trauma such as hyper-vigilance, exaggerated startle response, anxiety, poor regulation of affect, and depression which may worsen externalizing behavioral problems, decrease academic functioning, and hinder social skill development (p. 234).

Exposure to DV increases stress levels and has various negative physiological impacts, but not only are the effects physiological, but also exposure to DV actually changes the brain during development. Thornton (2014) contends that physical responses may include headaches, stomachaches, the inability to concentrate, and bedwetting. Some children may even be physically hurt by the perpetrator when attempting to intervene to help the victim (Domestic Violence Roundtable, 2008).
Exposure to DV and Relationships

Herrenkohl et al. (2010) postulate that in addition to all the negative effects exposure to DV has on the children, many children exposed to DV experience difficulties with relationships, often suffering from low self-esteem, social withdrawal, and anxiety. Oftentimes, children have not had the opportunity to learn social skills necessary in effective communication and conflict resolution (Foshee, Bauman, & Linder, 1999). According to the Domestic Violence Roundtable (2008), children who grow up observing their mothers being abused, especially by their fathers, grow up with a role model of intimate relationships in which one person uses intimidation and violence over the other person to get their way. Furthermore, as a result of living in constant fear, women who experience domestic violence may deny their children normal developmental transitions and the sense of basic trust and security that is the foundation of healthy emotional development (Levendosky et al. 2000). Oftentimes, children have not had the opportunity to learn social skills necessary in effective communication and conflict resolution (Foshee et al., 1999). The following sections will cover consequences children experience both in intimate partner relationships and in parent-child relationships.

Intimate relationships. According to Black et al., (2010), intergenerational transmission of violence has been a main theoretical consideration to explain the link between domestic violence in the family and intimate partner violence. Through observational learning, violence is used as a habitual response to conflict with intimate partners (Bandura, 1971). Bandura (1973), states that because the family is the main source of childhood learning, aggression between two parents teaches children that such behavior in an intimate relationship is appropriate and the consequences linked to
engaging in that behavior. Taking this into consideration, modeled behavior is more likely to be adopted if the behavior is seen as being advantageous (Black et al., 2010). Additionally, Foshee et al. (1999) indicate that children who have experienced violence in the home may not have had the opportunity to learn methods such as negotiation, verbal reasoning, self-calming techniques, and active listening, which affects their intimate relationships down the road.

**Parent-Child Relationships**

Domestic violence oftentimes has implications on parenting and the parent-child relationship as well (Barker et al. 2008). Belsky (1984) reports that according to the ecological model of parenting, it is believed that the caregiver’s stress level, available support, and psychological functioning, are all factors that predict the quality of parenting. The researcher posits that the more emotionally preoccupied a mother is with the violence and the more depression they experience, the less emotionally available they are for the children, which is linked to negative parenting (Belsky, 1984). According to Peled and Edleson (1992), preoccupation with life-stress and emotions may lead to battered mothers feeling not only less emotionally available, but increases their tendency to overlook or underestimate the emotional impact DV has on children exposed to abuse.

Barker et al. (2008) content that battered women are at greater risk of insecure mother-child attachment. Kellington and Mills (2012) support this in saying that children who have witnessed DV tend to have more disorganized attachment patterns. According to them,

this type of attachment can be observed when parents are both the primary source of care and simultaneously the source of harm or failed protection, and is
characterized be a sense of closeness to the caregiver in a disorganized way, appearing sad or fearful when reunited with them (2012, p. 5).

There is also evidence suggesting that children tend to treat their mothers the same way the abusive partners do. For instance, McCloskey, Figueredo, and Kiss (1995) reveal that behaviors and emotions displayed by the abuser such as yelling and hitting, are then modeled by the child. Perry and Chamberlain point out that when kids are chronically stressed, one of the problems commonly seen is difficulty in attachment and in bonding because they are so focused on survival, it is difficult for them to reach out to others, including their parents.

**Interventions**

With the negative effects DV has on children, it is imperative to take into consideration the interventions available to help children cope with and process the violence they have experienced. Kellington and Mills (2012) state that it is essential to note that the potential negative affects linked to exposure to domestic violence is not an unavoidable product of the traumatic experiences, but is rather a result of the trauma not being adequately processed. Birchmore (2012) proposes that one of the aims of group psychotherapy is to create an environment where shame-filled experiences and thoughts can be shared with one another in a way that allows clients to reconnect with other group members. Individuals can then develop a new type of interaction in which the relationships are trustworthy. The following interventions have been found to be effective in helping children process traumatic events.

**Psychoeducation.** Bridges, Karlsson, and Lindly (2014) assert that the high rates of intimate partner violence and the various negative consequences associated with DV
suggest that efforts towards prevention of domestic violence are needed. The Trauma-Focused Cognitive Behavioral Therapy website (TF-CBT, 2005) contends that children who have been traumatized are oftentimes confused and may not understand what happened and therefore one of the best ways to help traumatized children is to provide them with accurate information. The site postulates that psychoeducation helps to clarify inappropriate information that children may have received from the perpetrator or that they may have constructed on their own. Donker, Griffiths, Cuijpers, and Christensen (2009) define psychoeducation as an intervention that uses leaflets, posters, lectures, internet materials, and other resources to provide information, education, and/or feedback and advice to clients (p. 80). These researchers further differentiate between passive and active psychoeducation. Passive psychoeducation is defined as offering encouragement, but not providing explicit instructions as to how to carry out certain recommendations.

Lukens and McFarlane (2006), proclaim that psychoeducation is among one of the most effective evidence-based practices that has been utilized in both clinical trials and community settings. The researchers contend that psychoeducational techniques are used to help remove barriers to comprehending and digesting complex and emotionally loaded information and to develop strategies to use the information in a proactive fashion. They further claim psychoeducation is a part of many dating violence prevention programs (Lukens & McFarlane, 2006). However, Donker et al. (2009) inform that while psychoeducation is a common component of prevention and intervention programs, little research has been done on the effectiveness of psychoeducation alone.

Bridges et al. (2014) conducted a study designed to investigate whether brief, passive psychoeducation about DV would affect peoples’ knowledge about DV and
increase their recognition of abuse when reading scenarios. The study examined six different types of DV: physical, sexual, emotional, financial, environmental, and social. DV is perceived differently by different populations and therefore the study included different nationalities and ethnicities. A total of 128 participants were recruited for the study, but 26 were excluded due to not complete the entire survey; two participants were also excluded due to age limitations the researchers had set. The sample size therefore consisted of 100 participants, 72 of which were women and 28 men. The average age of the participants was 20.91 years, with the majority of participants being Latino (56%) and non-Latino White (38%). Two thirds of the participants in the sample were recruited in the United States and the remaining participants were recruited in Argentina. Recruitment flyers were placed at two college campuses in the Midwest United Stated and in Buenos Aires, Argentina (Bridges et al., 2014).

The Bridges et al., (2014) study was conducted online and was available in both Spanish and English, with the participants choosing whichever language they preferred. The participants were randomly assigned to either the experimental or control groups. The participants in the experimental received brief, passive psychoeducation regarding DV while the control group did not receive any information. The information received was a 1.5 single-spaced information sheet about domestic violence using materials from the Women’s Resources Website and the Centers for Disease Control and Prevention. The information sheet was created by the researchers to match other psychoeducation handouts commonly found in various resource centers such as doctor’s offices. A DV knowledge quiz was then completed, scenarios were read and responded to, and questions about demographics were answered. The results of the study showed that there was a
significant difference between the experimental group and the control group. The results provide evidence that participants who received the passive psychoeducation handout performed better on the DV knowledge quiz when compared to the control group (Bridges et. al., 2014).

**Art therapy.** Kozlowska and Hanney (2003) argue that art therapy can help children access procedural memory through the process of making art. Kellington and Mills (2012) report that Green emphasized that procedural memory is key to the treatment of trauma, as these types of memories are often located in the amygdala where responses to traumatic or ‘emergency’ situations like flight, fight, or freeze are determines. In order for traumatic experiences to be processed, the brain must be able to take the experiences from the amygdale and process them, calmly and reflectively, in the hypothalamus (2012, p.3). According to these researchers, the less anxious a child feels during therapy sessions, the higher the likelihood that the negative and painful memories of the traumatic experience can be rerouted and replaced. The belief is that children engaging in art therapy can derive enjoyment from the process and therefore they feel more comfortable with the therapy sessions (Kpz;pwska & Hanney, 2012). O’Brien (2004) proposes that the use of art materials may facilitate access to somatic memory, which is stored in the body associated with the emotional experiences of children. This makes art therapy especially useful in working with children who may have buried memories of the traumatic experiences.

**Play therapy.** Giordano, Landreth, and Tyndall-Lind (2001) explain that group therapy is a preferred treatment alternative with children who have been exposed to
domestic violence. However, due to agencies having limited child-focused therapists and enough resources to offer play therapy, many agencies are forced to utilize alternative group interventions. These authors suggest that toys enable children to express feelings and experiences that would otherwise not be easily communicated due to immature verbal development (2001). Incorporating play therapy into a group allows for children to interact and build socially meaningful relationships.

**School groups.** Another type of intervention consists of group interventions in schools aimed at children who have been exposed to DV. According to Deblinger, Pollio, and Dorsey (2016) group therapy is appealing to agencies because they have the potential of serving a large number of clients, while still keeping its efficacy. Thompson and Trice-Black (2012) assert that school counselors are often faced with domestic violence, which affects approximately 15 million children each year. They also report that the school environment offers an ideal setting in working with children who have survived trauma because all the children in school have accessibility to mental health resources provided by the school (2012).

Structured interventions are used in school-based groups. According to Thompson and Trice-Black (2012), structured interventions include techniques such as problem solving role-plays. Puppets, stories, art projects, and more. Jaffe, Wilson, and Wolfe (1986) propose using structured interventions because they promote children working together to create social, emotional, and behavioral skills to promote resiliency. They state that these techniques can be used to label feelings, build self-esteem, coping skills, safety planning, dealing with grief, and attitude towards violence. Yalom (2005) states that
in the therapy group, especially in the early stages, the disconfirmation of a client’s feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, clients report feeling more in touch with the world and describe the process as a ‘welcome to the human race’ experience (p. 42).

School-based groups allow children the opportunity to identify and process feelings, and is a beneficial setting because children have access to school mental health services.

Various studies have been conducted testing the effectiveness of group therapy in regards to children who have witnessed domestic violence. Kellington and Mills (2012) propose that one of the aims of group psychotherapy is to create an environment where children can share their experiences with one another, allowing children to reconnect with others and to develop a new sense of play and create trustworthy relationships. Thompson and Trice-Black (2012) assert that school counselors are often faced with domestic violence and that the school environment provides an ideal setting in working with children who have survived trauma because all the children there have access to mental health resources they do not have outside of the school.

**Diversity**

When constructing a process group for children who have witnessed domestic violence, it is necessary to take into consideration any issues of diversity that may arise. The National Online Resource Center on Violence Against Women (2016) states that cultural competence requires that practitioners recognize their client’s values, culture, language, race, ethnic backgrounds, religion, and other diversity factors. Another aspect of diversity to keep in mind is the reason behind women staying with the perpetrator. One
of the reasons immigrant women stay is out of fear of deportation or having the children removed. It is therefore useful to provide a safe space and assess the situation when working with children of immigrant women. Considering these factors when establishing groups is critical in ensuring the therapist is practicing culturally competent techniques and is providing the best care possible to survivors of trauma.

**Evidence-Based Treatment for Children Exposed to DV**

As with other therapeutic modalities, it is important to base the curriculum and interventions of the group on evidence-based research. Doing so will ensure the treatment of children with interventions that have been studied and proven to be effective. According to the NCCADV (2016) a number of evidenced based programs and therapeutic modalities have been proven to be effective when working with children exposed to violence. Treatments such as Parent-Child Interaction Therapy (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) have been shown to address the needs of children exposed to domestic violence. The NCCADV reports that a major emphasis of these programs are increasing a child’s sense of physical and emotional safety, developing stronger social skills, developing respect for others, and gaining a sense of control over one’s own life (2016).

**Trauma Focused Cognitive Behavior Therapy**

According to the Child Welfare Information Gateway (2012), TF-CBT is an evidence-based treatment approach shown to help children and adolescents overcome trauma related difficulties such as experiencing domestic violence and child abuse. TF-CBT is designed to target negative emotional and behavioral reactions following a child’s sexual abuse, domestic violence, traumatic loss, and other traumatic events. This
approach encourages children to face negative or distorted beliefs by providing a safe and supportive environment where children are encouraged to talk about their experiences.

Rubin et al. (2011) contend that due to its efficacy being replicated in experimental studies, TF-CBT is considered to be one of the best modalities used in treating traumatized children and their non-offending caregivers. The authors state that much of the empirical support for TF-CBT is in treating posttraumatic stress disorder related to sexual abuse, however it has also been extended to treat symptoms of PTSD, depression, and anxiety connected to other forms of physical abuse and domestic violence (Rubin et al., 2011). Cohen et al., (2006) contend that TF-CBT is not ideal for children who had preexisting behavioral difficulties prior to the trauma. However, the researchers believe it can alleviate some trauma-related behavioral problems. The researchers summarize the core values of TF-CBT using the acronym CRAFTS.

Components based

Respectful of cultural values

Adaptable and flexible

Family focused

Therapeutic relationship is central

Self-efficacy is emphasized (Cohen et al., 2006).

Murray, Cohen, and Mannarino (2013) contend that TF-CBT was developed to address multiple negative impacts of traumatic events for youth ages 5-17. The researchers postulate that TF-CBT has various components including psychoeducation, coping techniques such as muscle relaxation and deep breathing, cognitive coping, trauma narrative, conjoint parent-child sessions with the non-offending parent, and safety
planning. The researchers posit that safety is prioritized early in treatment and is a major component of TF-CBT. It is crucial to legitimize the safety concerns the child is experiencing early on and throughout the entirety of treatment. It is equally important to discuss unsafe or potentially situations that the family may not be acknowledging (2013). The safety plans should be very concrete and detailed and should be thoroughly rehearsed. It is also crucial that the safety plans be appropriate for the child’s developmental stages and that the non-offending parent is involved in the safety plan whenever possible and appropriate (Murray et al., 2013).

The Trauma-Focused Cognitive Behavioral Therapy (2005) website has an online training for clinicians to learn the techniques of TF-CBT. The first module discusses providing psychoeducation for children. According to Rubin et al. (2011) psychoeducation involves informing clients about trauma and psychosocial issues related to exposure such as PTSD. The researchers postulate that providing psychoeducation is important and must be done in a way that normalizes the child’s reaction to the trauma. When providing psychoeducation, the child’s thoughts should be validated so that rapport and trust can be established. “it is important to provide psychoeducation in a manner that normalizes client reactions to having been traumatized, that validates their thoughts and feelings about the assessment process, and that builds rapport and trust (Rubin et al., 2011). As discussed earlier, the TF-CBT website (2005) postulates that psychoeducation also helps to clarify inappropriate information that children may have received from the perpetrator or that they may have constructed on their own.

The TF-CBT web-based learning course (2005) states that the second module included provides three techniques for helping children manage their levels of emotional
arousal and stressful thoughts. The TF-CBT website contends that it is necessary that children develop a ‘toolkit’ of coping strategies to control their anxiety, because some strategies will work better than others. Strategies provided include controlled breathing, progressive muscle relaxation training, and thought stopping. Controlled breathing is a safe and effective breathing exercise that may help them control their anxiety.

Progressive muscle relaxation (PMR) is taught by tensing the body and then relaxing the body and releasing that tension. It is designed to help children distinguish between tense and relaxed feelings. PMR may help children control their anxiety when they are taught when and how to use the exercise. The third relaxation technique discussed in the module is thought stopping. The site posits that thought stopping and distraction strategies may be useful to use with children who experience disturbing and intrusive thoughts that interfere with their ability to concentrate on schoolwork, homework, or sleeping throughout the night. If the child is not experiencing this symptomology, it is okay to skip this coping technique. Thought stopping is accomplished by either telling the thought to ‘go away’ out loud and/or physically doing something to distract oneself from the unpleasant thought such as snapping a rubber band against their wrist to stop the thought (TF-CBT, 2005).

Murray et al., (2013) contend that even in cases where there is continuous trauma, research suggests TF-CBT can be used with youth and still significantly improve symptoms. Deblinger et al. (2016) state that TF-CBT has been increasingly utilized in a group format. According to the researchers, providing TF-CBT in a group format may reduce feelings of shame, stigma, isolation, and confusion experienced by the children as a consequence of the traumatic events. They further proceed to explain that this is very
important provided that research suggests that feelings of shame can be important predictors of long-term maladjustment as a result of abuse. The researchers also state that the growing interest in TF-CBT groups may be due to the increasing demand for trauma focused mental health services and the fact that group therapy is potentially more cost-effective (Deblinger et al., 2016).

**Parent-Child Interaction Therapy**

Barker et al. (2008) posit that PCIT is an evidenced-based practice that focuses on providing behavioral interventions to parents who have children ages 2 to 7 years old with disruptive behaviors. PCIT focuses on the parent-child relationship and in treating both the parent and the child simultaneously. According to the authors, treatment goals are accomplished through a two-phase process, with play being the main tool in changing dysfunctional parent-child interactions (2008). The first phase of treatment in PCIT is the Child-Directed Interaction (CDI) or Relationship Enhancement phase. During this phase, treatment focuses on building a positive relationship and attachment between the parent and child, while the child leads play activity. PCIT can then improve the quality of the parent-child relationship and assist in the development of secure attachment. The researchers postulate that “through live coaching and hand-on exercises, parents are taught PRIDE skills: praising the child, reflecting the child’s verbalizations, imitating the child’s play, describing what the child is doing during play, and using enthusiasm while interacting” (Barker et al. 2008, p. 497). For instance, instead of focusing on minor behavior problems such as whining, parents are taught to ignore the action and instead provide positive attention when the child is behaving in the desired way. Once the parent has mastered the CDI phase, they move on to the Parent-directed Interaction (PDI) in
which the parent learns to use developmentally appropriate and effective child
management skills to decrease unwanted behavior (Barker et al., 2008).

Barker et al. (2008) propose that when working with children and parents exposed
to domestic violence, PCIT may be a beneficial psychotherapeutic intervention for
mothers and their children. Throughout PCIT, parents are coached by a therapist and
given feedback contingent upon the therapist’s observations. The therapist speaks to the
mother throughout the exercise in a supportive and encouraging manner. The researchers
state that this is crucial for parents who have experienced domestic violence because they
may have low levels of confidence in their parenting and may also suffer from low self-
esteeem. PCIT improves the quality of the parent-child relationship and assists in the
development of secure attachment. It is believed that improving the quality of the parent-
child relationship will decrease the severity of the trauma symptoms experienced by both
the parents and the child. Additionally, PCIT has proven effective with diverse cultural
groups and low-income families so it is applicable to many populations. (Barker et. al,
2008).

Niec et al. (2005) postulates that although PCIT is traditionally implemented with
one parent and child, recent data suggests that PCIT can also be delivered in a group
format. No controlled studies have been conducted with group PCIT, however parent
trainings are frequently provided in group format and various group parent trainings have
been shown to be effective. The researchers content that having PCIT in a group setting
may be beneficial to parents because each parent-child interaction would be observed by
all other parents in the group, which would in turn allow optimal feedback during group
discussion. They content that PCIT groups run well with three to six families, but even
having two families benefits parents in that they can learn from others who have similar problems. Furthermore, group PCIT includes children in treatment sessions as provides live coaching to parents, whereas other parent training sessions do not. Thus, group PCIT may be more beneficial to the parents and ultimately the children. It is flexible in format and therefore may be effective with many different populations. Challenges with PCIT in group format include the need to ensure enough time for all participants to speak, monitoring for psychopathologies parents may have, and managing parent’s feedback to one another (Niec et al., 2005).

Summary

Research indicates that there are several adverse effects exposure to domestic violence has on children. An estimated 3.3 million to 10 million children are exposed to domestic violence every year. These children are likely to experience behavioral challenges, difficulties forming healthy relationships, and they may face developmental difficulties. Furthermore, children who have been exposed to domestic violence may develop PTSD.

The effect of domestic violence varies on the child’s developmental stage. A child’s developmental stage leaves them less able to convey their experiences, especially younger children who are not yet verbal. Some impacts exposure to domestic violence has on the child’s developmental stage include depression, anxiety, difficult paying attention, and impaired physical health (Israel and Stover, 2009). In addition to the impact on the child’s development, children exposed to domestic violence also suffer from confusion at not understanding the violence, fear, and anger when living on a DV household. Children exposed to domestic violence exhibit diminished empathy,
appropriate interpersonal skills, and experience feelings of self-blame and decreased self-esteem. Children exposed to DV may also exhibit anger, increased aggression, and substance abuse.

In addition to the emotional effects exposure to DV has, children living in households where violence occurs are also likely to experience physical symptoms such as difficulty sleeping and failure to thrive. Due to the constant danger in their household, children are often hyper-vigilant and may exhibit anxiety or depression. Not only does exposure to DV have negative physiological impacts, but exposure to violence actually changes the child’s brain development.

Children who have witnessed domestic violence oftentimes have difficulty forming healthy and meaningful relationships due to suffering from low self-esteem, social withdrawal, and anxiety. Due to the violence in the home, children have not learned how to use effective communication and conflict resolution. They may not have had the opportunity to learn skills such as negotiation, compromise, and active listening. The inexperience with these skills lead to difficulty forming relationships down the road. Children may also experience attachment issues. Children exposed to DV have been shown to have more disorganized attachment patterns.

Several interventions are useful when working with children who have been exposed to violence. Psychoeducation is an important tool to utilize when working with children. Psychoeducation allows the therapist to provide information about DV, normalize the experience, and provide the child with accurate information. Art therapy and play therapy have also been proven to help children feel less anxious during therapy.
Play therapy provides children with a safe space to express themselves when they are not comfortable verbalizing their experiences.

Evidence-Based treatments such as TF-CBT and PCIT have also proven to be effective for children who have been exposed to violence. TF-CBT provides the child with psychoeducation, cognitive restructuring, and relaxation techniques that the child can utilize to manage their anxiety. Techniques such as controlled breathing, progressive muscle relaxation, and thought stopping are all techniques that be utilized in a group format to reduce anxiety. Furthermore, research shows that TF-CBT is effective in a group format and may decrease the stigma of having witnessed violence in the home. Using TF-CBT in a group may reduce feelings of shame and guilt. PCIT can be used to improve the relationship between the mother and the child.

With all the adverse effects exposure to domestic violence has on a child, it is imperative to provide interventions and groups aimed at helping the children identify and express their emotions while providing support in a safe therapeutic environment.
Chapter 3

Project Audience and Implementation Factors

Introduction

This project presents a group curriculum for children who have been exposed to domestic violence. The group contains interventions from different treatment modalities modified to serve in a group setting and adapted to children who have been exposed to violence. As discussed, children exposed to violence suffer from a variety of adverse effects. The following chapter will review the development of the project, the intended audience, the qualifications needed to run the support group, any environment that is required, and an outline of the content presented in the curriculum.

Development of Project

The idea for the group curriculum stemmed from the need for support groups for children. When co-facilitating a support group for survivors of domestic violence, 90% of the members stated their children were not in any type of counseling. Counseling centers such as Strength United provide support groups for survivors of domestic violence, but there are no support groups for children who have been exposed to violence. Strength United offers “Child Enrichment Activities” in which therapeutic interventions are sometimes utilized with the children while their parents are in either parenting classes or support groups. However, the violence they have witnessed is never discussed. While Strength United offers individual counseling to children who have been exposed to violence, a group of peers would allow children to work on social skills, self-esteem, and reduce feelings of shame, guilt, and stigma associated with living in a DV household. A group format may also reduce the fear and shame associated with attending therapy. This
curriculum aids to assist counselors and counselor trainees working with children exposed to violence by providing them with a structured 8-week course full of interventions to reduce symptomology.

In order to construct the group curriculum, an extensive literature review was conducted. Online databases such as ERIC and Psychinfo were used to obtain peer reviewed articles detailing effects exposure to domestic violence has on children and interventions that have been proven useful when working with this population. Multiple sources were found to ensure the interventions were appropriate for children exposed to violence and studies were reviewed to determine the efficacy of therapeutic orientations. The extensive review of literature was used to identify adverse effects exposure to violence has on children. Once adverse effects were identified, interventions were then researched to address some of the adverse effects experienced by the children.

In order to identify appropriate interventions, a review of therapeutic orientations and interventions were utilized. Based on studies and past research, interventions will focus on relaxation techniques, safety planning, progressive muscle relaxation, and thought stopping. Interventions will also include art therapy, play therapy, and psychoeducation. These interventions are meant to improve self-image, reduce anxiety, fear, anger and shame. Psychoeducation will be used to provide information to children and replace any faulty information they learned from the offending parent or that they interpreted themselves.

**Intended Audience**

The process group for children of domestic violence will include children who have witnessed domestic violence, but have not experienced direct physical abuse as a
result of the DV. Anyone who has experienced physical abuse by a parent will not be able to join the group, as it would affect the universality of the members. While the DV experience will be unique to each child, limiting the types of abuse the child has been exposed to will limit the outsider feeling and help instill hope in change and establish group cohesiveness. In order to join the group, it will also be required that the offending parent is no longer in the home. While children currently experiencing domestic violence are also in dire need of therapy and support groups, interventions included in the group format will include activities the children can take home as well as safety plans. To ensure the safety of the children and non-offending parent, it is important that the papers be kept in a safe space. Therefore, to eliminate the risk of further violence, children who are currently in a DV household will be referred for individual counseling. The group will also be limited to children ages 9-12 so as to ensure there is not too large of a deviation in ages and the children are at similar developmental stages. Having older children may lead to too big of an age gap where children do not feel at liberty to process the traumatic events they experienced.

The group curriculum is also intended for therapist or therapist trainees and interns. Strength United utilized the TF-CBT model when conducting individual counseling, but in a group format interventions from different therapeutic orientations will be used. In clinical supervisions, counselors oftentimes present cases where a child who has been exposed to violence is reluctant to speak about the events they witnessed. There is oftentimes a sense of shame associated with the violence. Providing a group curriculum for counselors will provide the counselors and family members of the children with another form of therapy. The group would provide a more supportive environment
where children would not be forced to speak, however they would be engaged by the activities and having witnessed violence would be normalized by the other group members.

**Personal Qualifications**

The group curriculum is meant to be utilized by therapist trainees and interns. Familiarity with TF-CBT is encouraged, as various interventions are pulled or adapted from that modality. It is recommended that trainees and interns complete the 10 hour TF-CBT online workshop prior to running the group. Additionally, trainees and interns should familiarize themselves with the effects exposure to domestic violence has on children at their different developmental ages. It is also vital that the trainees or interns seek weekly clinical supervision by a licensed mental health practitioner to ensure proper use of the interventions and to discuss any issues that may arise. Should anything arise in session such as possible ethical or legal issues, or anything that the trainee/intern may be mandated to report, it is necessary for the trainees/interns to call their supervisor immediately.

**Environment and Equipment**

Clients should be seen in a larger room with chairs and tables set up in a circle. If the group has co-therapists, the therapists should sit opposite from each other to encourage more engagements of group members and to make the children more comfortable. Having both therapists sit at the head of the table can be intimidating and reduce group cohesiveness, in addition to making it difficult to build rapport. White noise makers should be utilized outside of the room to ensure confidentiality of the group, and to limit the disturbance the group may cause to adjoining rooms. The group curriculum
should be in a binder, with each session labeled for easy access. Counselors will be required to make copies of the handouts prior to the group commencing. Additionally, counselors should be prepared with the necessary materials listed in the handouts. Some of the materials the counselors will need are colored pencils, pencils, pens, construction paper, handouts, flour, balloons, mason jars, glycerin, soap, and glitter. Books will also be used in sessions to provide psychoeducation, so the counselor should be prepared with the correct books.

At the first and last sessions, counselors will also be asked to utilize the Trauma Symptom Checklist for Children (TSCC) to determine the severity of symptoms experienced by the children. According to the U.S. Department of Veterans Affairs (2016) the TSCC is a 54-item self report scale that was originally designed for trauma symptoms related to sexual abuse and other traumatic events. The TSCC is made up of two validity scaled and six clinical scales including anxiety, depression, posttraumatic stress, sexual concerns, dissociation, and anger. The child is given a booklet containing a list of thoughts, feelings, and behaviors and is asked to mark on a scale of 0-3, how often these symptoms occur with 0 being never and 3 being almost all of the time.

Formative Evaluation

In order to ensure the usefulness of the support group and the need for a group for children, members of Strength United were asked how beneficial the group would be. The project was discussed with other counselor trainees and interns in order to get input about the usefulness and effectiveness of the project. Interventions were discussed with licensed marriage and family therapists to ensure their effectiveness. If the group were
utilized, members would be asked to fill out a short survey rating their experience with the group and any recommendations for future use.

**Project Orientation**

Due to the nature of the group, the leader would need to employ a collaborative approach. The basis of the group will be formed around using art therapy, play therapy, and interventions used in TF-CBT in conjunction with collaborative dialogue. The process group will be closed as to allow for children to form bonds with one another and have consistency throughout. “Closed groups can be time limited and goal oriented” which would be ideal for children to process the domestic violence (Jacobs, Masson, Harvill, & Schimmel, p. 50, 2012). Jacobs et. al state that in most cases, a closed group is more beneficial to members because it allows for trust and comfort to be established in group. To ensure every child has the opportunity to participate in session, and to ensure the counselor is able to focus on all the children, the group will be limited to a total of 6 children.

The process group would meet once a week to ensure that the children do not get bored of the group, but the meeting will be frequent enough that children remember the last meeting and are ready for the new session to begin. Holding the group in the morning would be preferable so that the children have enough energy to be engaged in the group process and are able to stay present throughout the hour and a half sessions. However, due to the children being in school, early afternoon groups would work as well. The counselors should be careful to avoid times when the children will be tired such as directly after lunch or too late at night. To establish group cohesiveness, it would be required that the children’s attend every session, with the exception of being sick.
Allowing the children to miss too many sessions in an eight week group will drastically impact the cohesiveness of the group as well as decrease the benefit to the individual. Counselors will not assign any homework assignments as it may not be safe or beneficial to encourage the child to process the traumatic events outside of the safe space of group. All materials needed for group such as art supplies, books, and toys will be provided by the counselors.

Session 1: Introductions/Build Rapport

The first session will focus on building rapport between the therapist and the children, and between all group members as well. The first session will also serve to establish the purpose of the group and provide brief psychoeducation on what therapy is and why the children are there. Yalom (2005) reports that a study conducted showed that concerns of group therapy includes the lack of confidentiality, therefore counselors will need to establish rules of the group and provide a simple explanation of confidentiality. The counselor should then explain the TSCC and hand the booklets out to the children. Once the assessments are complete, the group will begin with an ice breaker of the therapists choice. Child will then fill out the “All About Me” handout provided in the curriculum and asked to share some of their answers.

Session 2: Cycle of Violence/Safety Planning

Session two should continue building rapport and encouraging group cohesiveness. Counselors should explore warning signs of a DV episode and provide psychoeducation on the cycle of violence. According to the TF-CBT site (2005), psychoeducation helps to clarify inappropriate information that children may have received from the perpetrator or that they may have constructed on their own. Explaining
the cycle of violence will work to decrease some of the confusion regarding the inconsistency at home. A handout on the cycle of violence should be provided to the child. During this session, counselors should discuss safety planning and use the provided safety plan to help children plan a course of action they can take should the violence occur again. Murray et al. (2013) posit that safety is prioritized early in treatment and is a major component of TF-CBT. Give the children the “How am I feeling today” chart to assess how the session went. Counselors should end the session with controlled breathing.

Session 3: Myths vs. Facts

Session three should consist of the counselor checking in about the previous session and briefly reviewing the safety plan. Counselor should discuss the myths vs. facts handouts for children. Client should engage children in a discussion about these handouts. Counselor should pay careful attention to emotions or cognitive distortions disclosed by the clients. Counselor should then utilize the self-esteem quiz provided in the curriculum. Counselor should end the session with the progressive muscle relaxation provided in the handouts. The TF-CBT (2005) site contends that PMR may help children control their anxiety when they are taught when and how to use the exercise.

Session 4: Playdough

Therapist should provide playdough for the children to provide sensory stimulation while they begin to engage with one another. Different color playdough should be available and the children should be instructed to sculpt something that tells the rest of the group who the child is. Therapist should then ask questions regarding the colors chosen and why the child chose to construct that sculpture. This will provide
insight as to what is important to the child. If there is enough time after everyone has shared, the children should use the playdough to identify emotions. An emotion handout can be provided if the children are having difficulty. The counselor should then ask the children what emotion they depicted and when they have felt that way. Giordano, Landreth, and Tyndall-Lind postulate that using play therapy will encourage the child to interact and form meaningful relationships.

Session 5: Drawing

The children will be asked to draw a picture of themselves and their family and using an art therapy interpretation/scoring book, the therapist will assess the drawings. The assessment is not a complete diagnostic tool and therefore cannot be used alone, but it will help provide the therapist with information about the child’s perception of themselves and their family. It will also assist in identifying instances of abuse and fears the children may have. Counselor will engage children in conversation about their drawing and ask them to share their pictures. Counselor will identify any negative emotions depicted by the childrens’ drawings. Children will then fill out the self-care handout provided in the curriculum. Kellington and Mills (2012) posit that engaging in art therapy can derive enjoyment from the process and therefore they feel more comfortable with the therapy sessions.

Session 6: Identifying Anger

Barker et al. (2008) contend that child witnesses have increased levels of aggression, anger, and defiance towards parents. During this session, counselors aim to develop coping skills children can use when feeling angry. Counselor will begin by asking the children if they know what anger is and how they know someone is angry.
Children will then be asked to give examples of what they do when they are angry. Counselor will then proceed to read “Moody Cow” to the children or ask for volunteers to read the story. “Moody Cow” will help the children identify and express feelings of anger and will provide an activity children can use to manage their anger. The counselor should have all materials ready for the child and encourage them to place angry thoughts, represented by glitter, in a jar.

Session 7: Stress Balls

Research shows that effects of exposure to domestic violence in children include anxiety and depression (Israel and Stover, 2009). In this session, counselors will discuss anxiety with children and ask if they ever experience symptoms of anxiety. Counselors should encourage children to discuss how anxiety plays a role in their daily life and if there are times when they are able to overcome the anxiety. Counselors should then review coping strategies the children have learned thus far and introduce stress balls. Stress balls can be used when the child feels angry or anxious about daily issues. All supplies should be ready prior to the session beginning.

Session 8: Conflict Resolution

Session eight will focus on conflict resolution. According to the Domestic Violence Roundtable (2008), children who grow up observing their mothers being abused grow up with a role model of intimate relationships in which one person uses intimidation and violence over the other person to get their way. Due to the lack of good role models, children have difficulty forming meaningful relationships. In this session, counselors should allow children to generalize positive conflict resolution attributes to their school life and other areas. Ex: Avoiding conflicts at home leading to resiliency and the ability
to walk away from arguments at school. Counselors will then discuss conflict resolution and provide puppets the children can use to role-play. Counselors will encourage children to role-play conflict resolution and provide praise on the progress of the children.

Session 9: Self-Esteem

Fantuzzo and Mohr (1999) indicate that children witnessing DV also have feelings of self-blame and exposure to DV has been linked to decreased self-image and self-esteem. This session aims at increase positive self-image. In the ninth session, the child is provided with three sheets of paper and colored pencils. On one sheet of paper children are instructed to either draw or write how they see themselves, on the other the child is asked to draw how the world sees them, and on the final one they are instructed to write or draw how they want to be seen/see themselves. Counselor should then go around the room and have each member share their drawings. Counselor can challenge any negative beliefs the child has and encourage each member to say something nice about that child to boost their self-image. Fantuzzo and Mohr (1999) indicate that children witnessing DV also have feelings of self-blame and exposure to DV has been linked to decreased self-image and self-esteem. This session aims at increase positive self-image.

Session 10: Maintenance/Termination

In the final session, counselors should explore feelings regarding termination and discuss how children will maintain coping strategies developed in the group. Review safety plan. A Windows Between Worlds intervention will be used during the last session. The children will make journey butterflies and the counselor will read the
accompanying story. The children will then have a take-away from their time in the group. The children will also need to complete the TSCC during the last session.
Chapter 4: Conclusion

Summary of Project

The purpose of this project is to create a 10-week group curriculum for children who have been exposed to domestic violence in their home. According to Israel and Stover (2009) “children’s symptoms may include difficulty with sleeping and eating, family and peer relationships, attention, academic performance, depression, anxiety, aggression, low self-esteem, posttraumatic stress disorder symptoms, and impaired physical health”. The group aims to decrease these symptoms. The group is designed to be conducted by therapist trainees or interns, but they must seek weekly clinical supervision where they can discuss the cases. If an issue arises during one of the sessions, counselors must call their supervisors immediately. The interventions provided in the curriculum are a mixture of TF-CBT, play therapy, and art therapy.

Children seen at Strength United are seen as individual clients, and when they are under 12, they are seen in “Child Enrichment” groups. These groups serve mainly as childcare groups so that the parents may attend parenting or domestic violence classes. Therapeutic interventions are utilized during these sessions, but there is no real structure to the group. The inspiration for the group stemmed from listening to counselors discuss the reluctance of children to open up in individual counseling sessions and having parents disclose that their children were not enrolled in therapy. The interventions utilized in the group curriculum are aimed at increasing self-esteem, developing coping mechanisms, reducing anger and anxiety, and providing a safe environment where children can build interpersonal relationships. The Trauma Symptom Checklist for Children (TSCC) is utilized to assess the severity of children’s symptomology before and after the group.
Recommendations for Implementation of the Project

In order to successfully apply this curriculum, the counselor must have a reasonable understanding of the types of domestic violence children may be exposed to. The counselors should also be aware of the effects domestic violence has on children and how witnessing domestic violence causes these symptoms. It is recommended that counselors intending to implement this group curriculum undergo the ten hour TF-CBT online training session as relaxation techniques used in the group are pulled directly from the training modules. Counselors should also be familiar with mandating reporting laws as children may disclose issues that the counselor is mandated to report. Familiarity with law and ethics is also crucial to ensure the counselors are appropriately maintaining client confidentiality, which oftentimes is confusing when working with children. Due to the age range being 9-12, the counselor’s should be careful to obtain parental consent for the younger group members and carefully explain consent and confidentiality to both parties.

Counselors should also familiarize themselves with the cycle of violence and different phases in the cycle. Knowledge of the cycle is crucial when providing psychoeducation to children and when discussing facts vs. myths. It is also important to know the cycle so the counselor can help children identify different phases they have witnessed and allow them to process emotions stemming from witnessing the DV. Furthermore, knowledge of the cycle will help the counselor’s identify any safety issues, which will be necessary when assisting children in constructing a safety plan.

Recommendations for Future Research

This group curriculum is intended to serve as a ten-week support group for children who have been exposed to domestic violence. Future research on the topic may
include a thorough literature review on the benefits or detriments of including the non-offending parent in therapy as well, as is the case with individual TF-CBT and PCIT therapy. It may be beneficial to have conjoint sessions throughout the group, with the possibility of adjusting the length or number of sessions to include all interventions in the curriculum. Conjoint sessions may provide a safe setting where children and parents can learn about the cycle of violence and create a safety plan together. Furthermore, the group may serve to improve the parent-child relationship.

Focus should also be placed on other symptoms that this group does not cover. Research shows children exposed to violence also suffer from depression, poor school performance, difficulty concentrating, and other adverse effects. The group curriculum provided focuses on anger, self-esteem, and anxiety. Some locations such as schools may have the opportunity to run year long or semester long groups, in which more interventions can be added to address different symptomologies. If the group takes place in a group setting, confidentiality rules should be covered extensively.

**Conclusion**

Domestic violence is an issue that affects not only the individual who is directly suffering from the abuse, but it affects the children in the household and other family members. An increasing number of children are being exposed to violence and not seeking treatment for the traumatic events. Researching the issues children with exposure to domestic violence face has been a sobering and slightly sad experience. It highlighted the need for interventions counselors can utilize with children. The idea to place these interventions in a group setting and create a group curriculum was inspired by the DV support group. The members of the group were able to bond and create friendships
outside of the group, and children who often feel shame, guilt, and stigma due to the DV
deserve the same opportunity.

Working with both women and children who have been exposed to domestic
violence has been an invaluable experience. Being granted the opportunity to work with
survivors of trauma and implement interventions that work and elicit noticeable change
has been amazing. The dedication of all counselors and staff working at Strength United
is inspiring and has been a large part of the motivation behind this project. The project is
also inspired by the clients who have granted us the opportunities to work with them, who
have opened up and shared their experiences, and who have chosen to take the first step
in healing- it has truly been a pleasure. While the curriculum has been a long process, it
has been a pleasure dedicating time and effort into constructing a group that will benefit
children who have experienced traumatic events.

I welcome and encourage other mental health practitioners to consider
implementing this curriculum when working with children who have witnessed violence
in their household. Children are vulnerable to the DV and oftentimes internalize the DV,
believing it is somehow their fault. This curriculum is intended to increase self-esteem,
develop coping skills, and improve interpersonal relationships. Doing this will hopefully
help children cope with what they have experienced.
References


HELPING OUR CHILDREN: A
SUPPORT GROUP FOR CHILDREN OF
DOMESTIC VIOLENCE

By Zuneybi Contreras
MFT Trainee
Strength United
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Introduction

The following curriculum offers interventions for children who have been exposed to domestic violence. The group is meant for children aged 9-12 who have witnessed domestic violence, but have not experienced physical abuse as a result of the violence. The curriculum provides interventions for a ten-week group with each session lasting one and a half hours in length. Interventions include play therapy using puppets and playdough, art therapy, psychoeducation, and self-esteem worksheets.

The curriculum is designed to be utilized by therapist trainees or interns. It is recommended that counselors familiarize themselves with the types of domestic violence and the effects DV has on children prior to implementing the group interventions. Trainees and interns should also complete the ten hour TF-CBT online training prior to facilitating this group, as some of the interventions come from that model. Please note: trainees and interns should seek weekly clinical supervision by licensed therapists where they can discuss any issues that arise during session. If a child reports something that the counselor may be mandated to report, counselors should contact their supervisors immediately.

Note: While informed consent is included in this curriculum, it should be adjusted to fit the needs of the agency. This group was intended to be free of cost to families, and as such that is reflected in the informed consent.
Session 1: Introductions and Building Rapport

Objectives:

- Review informed consent and establish group rules
- Build rapport between the therapist and group members
- Provide psychoeducation on therapy and the purpose of the group

Interventions:

- Include parents in the first part of the group to sign informed consent paying careful attention to limits to confidentiality.
- Discuss group rules and allow children to ask any questions or raise concerns regarding the rules.
- Explain the Trauma Symptom Checklist for Children (TSCC) and emphasize that there are no right or wrong answers. Hand out the booklet.
  - “I am going to hand out a booklet of questions. It is a little long; there are 54 questions in it, but you can take as long as you need. Your job is to answer them as honestly as you can. If you feel like these things never happen to you, put a 0. If you feel like it happens to you almost all of the time, put a 3”
- Assign children to complete the “All About Me” handout

Talking Points:

- After discussing confidentiality, ask children if they have any questions about what is kept in the room. Therapist should use active listening and reflecting to discuss concerns.
- Explain therapy and the purpose of the group. “Therapy is a place for you to talk about things that are hard to talk about elsewhere”
- Review the “All About Me” handout and encourage children to share with the group.
Domestic Violence Support Group Contract and Consent to Treatment

Instructions
Please read the following instructions carefully, initialing each section in the box on the left-hand side. If there is any part you do not understand, please ask counselor to explain it prior to initialing the section or signing the end of the document.

Consent to Treatment
______ I/we, the undersigned client or the parent/legal guardian if the client is a minor, request, consent to, and authorize __________________________ (therapist) to provide mental health services that may be deemed advisable for myself or my child.
______ I/we acknowledge that the person assigned to myself or my child may be a therapist trainee or intern with the unofficial title of therapist. As such, I acknowledge and accept that the therapist trainee or intern will seek weekly supervision and discuss my/my child’s case in either an individual or group setting.
______ I/we acknowledge that while many people may find psychotherapy helpful, I or my child may begin to feel worse before starting to feel better
______ I/we understand and accept that what my child discloses during session is confidential. However, the assigned therapist will reveal any information that would affect the safety of the child. I understand that I/we may end therapy at any time.

Confidentiality and Privilege
______ I/we acknowledge and accept that __________________________ (therapist) adheres to the standards of confidentiality and privilege defined by ethical counseling practice
______ I/we acknowledge that there are limits to confidentiality and privilege, which arise from certain California legal and ethical mandates. The exceptions are:
  • The obligation to report to authorities, without the client’s consent, any suspicion of abuse, endangerment or neglect, either physical or sexual, of any child or dependent adult
  • The duty to warn the intended victim and the authorities if it appears the client, or person known to the client, intends to harm another person
  • The need to take appropriate action when it appears that the client will make a suicide attempt or to prevent such an attempt
  • When disclosure is required pursuant to a legal proceeding
In each of the above cases an attempt will be made to inform the client that a report will be made. The client will be encouraged to make any report necessary to the authorities themselves.

Cost of Services
______ I/we understand that the support group for children who have witnessed domestic violence is a 10-week course that is free of charge.
**Group Times and Cancellations**

I/we understand that group sessions last 90 minutes in length. Attendance is important to ensure the child is benefiting from the group.

I/we acknowledge and accept that if I/my child cannot attend session, I will contact the group facilitator 24 hours in advance.

**Contacting My Therapist**

I/we understand that if I/we need to contact the group facilitator regarding a non-urgent matter, I/we can reach the facilitator at _______________________. My/my child’s therapist will attempt to call me/my child back as soon as possible, however this may not be immediately.

I/we agree that in a life-threatening emergency, I will contact 911 or go to a local emergency room.

**Agreement**

I have read and fully understand all of the above terms and conditions and agree to abide by this contract as a condition of receiving services

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Client Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Name</td>
<td>Parent/Guardian Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Facilitator Name</td>
<td>Facilitator Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
The following rules are to make sure the group is a safe space for everyone involved. Rules must be followed at all times.

1. Respect other people’s stories, feelings, and thoughts.

2. Do not make fun of other people.

3. It is okay to make mistakes.

4. It is okay to have feelings and cry or be angry, but you have to be careful how you show you’re angry.

5. If someone is hurting your feelings, say something.

6. It is okay if you do not want to share, but you are encouraged to try.
ALL ABOUT ME

1. My name is ____________________________________________

2. I am ____________________________________________ years old

3. I have ____________________________________________ brothers/sisters

4. I live with __________________________________________

5. My favorite color is ____________________________________

6. My favorite food is ____________________________________

7. My favorite activity is __________________________________

8. I am good at _________________________________________

9. I am happy when ______________________________________

10. I am sad when _________________________________________

11. I get angry when _______________________________________

12. My best memory is _____________________________________

13. My worst memory is ____________________________________

14. My proudest moment is _________________________________

15. Something I want people to know about me is ____________________________

________________________________________________________________________

________________________________________________________________________
Session 2: Cycle of Violence & Safety Planning

Objectives:
• Provide psychoeducation about the cycle of violence.
• Discuss safety planning.
• Develop coping mechanisms.

Interventions:
• Create a safe therapeutic environment using active listening and reflecting. This will allow children to feel more comfortable opening up.
• Provide psychoeducation about the cycle of violence. Be sure to keep the discussion age appropriate. Review the cycle with the children.
• Explore why safety plans are important and construct one.
• Assess how the session went for each child by assigning them to fill out the “How Am I Feeling Today” sheet. Have child fill this out after every session.
• Teach and demonstrate Controlled Breathing.

Talking Points:
• Reiterate that the cycle is not the child’s fault.
• Have any of you ever experienced any of these stages?
• What do you normally do if you are in the crisis stage?
• When people are fighting in the home, it is important that you stay safe and not get involved. What does safety mean to you?
• What can you do to stay safe if this ever happens again? Fill out safety plan.
• Use Subjective Units of Distress (SUDS) before and after EACH session. “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.

*Note: There are two handouts for the cycle of violence. One is for group facilitators and includes possible interventions at each stage. The children’s version uses more child appropriate language and does not include interventions. Facilitator should familiarize themselves with both prior to session.
Cycle of Violence - For Group Facilitator

**Tension Building Phase**
- Abuser starts to get angry
- The abuser may become extremely critical, moody, and demanding
- Breakdown in communication
- Victim tries to control the situation by pleasing the abuser
- Victim and family may feel like they are walking on eggshells
- The abuser’s negative behavior escalates and may begin to include threats
- Tension reaches a boiling point
- This may be when victims seek assistance

**Explosion/Crisis Stage**
- Violence begins
- Violence may include extreme emotional or physical violence
- Unpredictable and out of the victim’s control
- Motivated by an external factor or by the abuser’s emotional state
- Appropriate interventions may include medical attention or safety planning.

**Honeymoon Phase**
- Abuser may feel ashamed of his behavior
- Tries to minimize the abuse and will sometimes blame it on the victim
- May exhibit kind and loving behavior
- May apologize and attempt to convince the victim and family that the abuse will not happen again.
- This strengthens the bond between the abuser and the victim and can convince the victim to stay
- The victim needs support and information to help identify the violent behavior.

Cycle of Violence

Instructions: Please underline or circle any of the things you have experienced/seen

**Tension Building Phase**
- Someone starts to get angry
- They may start to become extremely moody and demanding
- Hard time talking to them
- The other parent tries to make the angry one happy
- Family has to be careful with what they say and do

**Explosion/Crisis Stage**
- Violence begins
- The angry parent may hit the other parent or start yelling and saying mean things
- You don’t know when it is coming

**Honeymoon Phase**
- The angry parent may feel bad for his behavior
- Tries to say it wasn’t a big deal
- Very sweet and loving behavior
- May say sorry and promise it will not happen again

Safety Plan

When people are fighting, remember to stay SAFE.

- Stay out of the fight
- Ask for help
- Find an adult who can help you
- Everyone knows it is not your fault

1. What does safety mean to me?

_______________________________________________________________________
_______________________________________________________________________

1. What can I do to stay safe?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

1. Where can I go to make sure I am safe?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

1. How can I get out of a dangerous area?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

1. Who can I call to talk to?

_______________________________________________________________________
_______________________________________________________________________

Utah Domestic Violence Coalition. (2016)
HOW AM I FEELING TODAY?

Instructions: Place a circle around the emotion that you are feeling after today’s session. If you feel more than one emotion, that is okay. You can mark more than one. If you feel an emotion that is not on this page, please draw or write it down.
Controlled Breathing

Today we are going to be learning a way to help ourselves calm down and control our feelings when we are nervous or upset. We are going to learn a special way of controlling the way you breathe that can help you calm down and feel better. It is easier to control your feelings when you control your breathing. Controlled breathing is also something you can do anywhere you want anytime you want. When you get really good at it, you can show your parents how to do it too.

First

Sit down in your chair and get comfortable.
Okay, now put one hand right above your belly button and one on your chest.

Second

Okay now we are going to breathe in.
Pay attention to the hand on your stomach. Your hand should be moving up when you breathe in and down when you breathe out.
Now pay attention to the hand on your chest- this hand should not be moving at all.

Third

Okay, now let’s breathe more slowly.
Make sure the hand on your chest is not moving and the hand on your tummy is moving up and down.

Last

Now let us add a word.
When you breathe out, say “relax” or “calm”.
Keep doing this until you are not feeling as nervous or upset.

Trauma Focused Cognitive-Behavioral Therapy (2005).
Session 3: Myths vs. Facts

Objectives:

• Verbalize adherence to the safety plan.
• Provide psychoeducation about common myths concerning domestic violence.
• Assess self-esteem
• Develop coping skills children can utilize when feeling anxious or angry.

Interventions:

• Allow children to ask questions or state concerns from the previous week.
• Provide psychoeducation about domestic violence and discuss common myths.
• Assign children to fill out self-esteem quiz.
• Have child fill out “How I Feel Today” sheet provided in previous week.
• Teach and demonstrate Progressive Muscle Relaxation (PMR).

Talking Points:

• Begin the discussion by asking the children if they remember what was covered the previous week. Ask children to verbalize what they remember from their safety plans.
• Review the handout on myths vs. facts. This is not meant for the children to take home, but rather to elicit conversation. Counselor should read the myth and ask the children their thoughts on the statement.
• Where appropriate, counselors should ask children if they have had any experience with any of the statistics.
• When children fill out the self-esteem quiz, quickly review it and look for any low scores. Encourage children to discuss questions, but it is okay if they are not comfortable.
• Introducing PMR: “Sometimes we all feel a little on edge, or nervous. When we have those feelings, our bodies can sometimes get tense or tight. This is an uncomfortable feeling- sometimes it even hurts to be tense. To help get rid of those tense feelings, we’re going to figure out a way to help you learn to relax your body. This will help you feel looser and calmer”
• SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.

(Trauma Focused Cognitive Behavioral Therapy, 2005).
Myths vs. Facts

**Myth:** Domestic Violence only happens to poor people

**Fact:** Domestic Violence happens to all kinds of families. It doesn’t matter how old the person is, their religion, if they have money or not, or what gender they are.

**Myth:** Some people deserve to be hit

**Fact:** No one deserves to be hit. It is wrong to hit someone, even if they are a part of your family. It is against the law.

**Myth:** Someone hits another person because they cannot control themselves.

**Fact:** Studies have shown that domestic violence happens because one person’s wants to control the other partner, not because they are all of a sudden angry.

**Myth:** Domestic Violence is a personal problem only between two partners.

**Fact:** DV affects everyone.

**Myth:** DV does not happen a lot.

**Fact:** About 1 in 3 women have been abused by a husband or a boyfriend. Sometimes, the partner even hits the children.

**Myth:** Abuse always means someone is getting hit.

**Fact:** Abuse does not have to be physical. Abuse can also be emotional, which can be just as harmful.

**Myth:** If the violence doesn’t happen that bad, then it is not that serious.

**Fact:** The violence does not need to happen often because the threat is still there. It does not matter if the violence does not happen a lot, every time it happens the victim is scared it will happen again.

**Myth:** If the person who hit someone says sorry after, then it is okay and it is going to stop.

**Fact:** Most abusers who hit people apologize, but that is how they control the other person. They make the victim think they are sorry and it will never happen again, but it is how they get the other person to stay.

DCADV (2016).
**Self-Esteem Quiz!**

Instructions: Please read each of the following statements carefully. If you do not understand what something means, please ask. On the blank line, write a number 1-3.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never true</td>
<td>Almost never true</td>
<td>Sometimes True</td>
<td>True</td>
<td>Always True</td>
</tr>
</tbody>
</table>

1. I feel that I am a good person
2. I am able to do things just as well as other people
3. I am happy with who I am
4. I think I have good values
5. I can laugh at myself
6. I like being myself, even when other people
7. I like who I am becoming as a person
8. I respect myself
9. I feel comfortable telling people what I think
10. I am a good friend and people like to be with me
Progressive Muscle Relaxation

- Sit up in a chair
- Okay now first, point your toes back up towards your head. Feel all the muscles tensing up in your feet, ankles, and lower legs.
- Relax your feet. Focus on the different way your feet feel now
- Straighten your right leg and lift it off the chair
- Feel the tension on the top of your leg and in your stomach
- Let go and relax. Let your leg return to the chair.
- Lift your other leg and do the same.
- Tighten your stomach for 15 seconds. Let go and feel the difference.
- Stick out your hands and make your hands into a tight fist. Squeeze as hard as you can. Hold for 15 seconds. Hold and let go.
- Tense your neck and hold for 15 seconds. Let go and focus on the difference.
- Now put on a huge smile, as big as you can. Feel the muscles in your face tense. Hold for 15 seconds and let go.
- Now wrinkle your forehead. Hold for 20 seconds and then let go.
Session 4: Playdough

Objectives:

- Verbally identify and express feelings
- Increase self-awareness

Interventions:

- Through the use of playdough, have child create a sculpture that tells you about who the child is, what he or she likes, or something that the child would like to share about themselves. Counselor should create a sculpture at the same time.
- If there is enough time, discuss emotions with the children and have them demonstrate an emotion with their playdough.

Materials:

- Playdough

Talking Points:

- Once the children have completed the sculpture, ask the following questions of every child:
  - What do you call this?
  - What feeling do these colors represent?
  - If your sculpture could talk, who would it want to talk to and what would it say?
  - What does your sculpture want the world to know about it?
  - Why did you choose this sculpture?
- Once each child has had a chance to discuss their sculpture, move into feelings talk.
  - How did that activity make you all feel?
  - Can you use your playdough to show me a different feeling?
  - Can you give me an example of when you felt that way?
- SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.

Adapted from Lowenstein, (2008).
Instructions:

Using the Playdough, create a sculpture of something that tells the group a little about who you are. The sculpture can show something that you like to do, something that you are good at, or just something that you would like to share with the group. When you are done, you will be asked to share about your sculpture and what it means to you. Take your time and do your best.
Session 5: Self-Portrait

Objectives:
• Assess child’s self-image
• Assess any fears regarding family violence the children may have

Interventions:
• Assign children to draw a portrait of themselves
• Assign child to draw a picture of their family
• Assess any violence the drawings depict and review safety planning with the children.

Materials:
• Colored Pencils
• Paper
• Handout
• Pen/Pencil

Talking Points:
• Invite children to share their drawings with the group
• Ask members to identify each member and what is happening in the picture
• Notice anything unique and ask children why they chose to draw those things.
• In the family, pay close attention to any one person who stands out. And ask the child about it. Ex: “why is that person all alone? Why is that person so much bigger than the rest? Why does that one look angry?”
• If the drawing depicts violence, make sure to review safety planning.
• SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.

* Note: Counselor should also do both of the drawings and share their experiences with the group members.
Session 6: Identifying Anger

Objectives:

- Verbally identify and express feelings of anger.
- Increase coping skills children can utilize when feeling angry.

Interventions:

- Create a safe and warm environment where children can explore their relationship with anger.
- Assess how anger manifests itself in the family.
- Provide psychoeducation about anger through the book “Moody Cow Meditates” by Kerry Lee Maclean and use the Mind Jar example in the book as a coping mechanism.

Materials:

- Mason jars
- Glycerin
- Glitter
- Hand soap

Talking Points:

- Ask children to show you their angry faces.
- “What do you think anger is? What does it feel like?”
- Ask children to give examples of times they have been angry and how they show they are angry.
- After reading Moody Cow, ask children what they thing the story was saying and what they thought of a mind jar.
- Have the children ever tried meditation?
- Proceed to the mind jar activity, focusing on the events the children say make them angry and asking them how else they can express that anger. Remember, it is okay and normal to be angry, as long as you express anger the right way.
- SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.
Moody Cow Mind Jar

Materials Needed:

- Small empty glass jar
- Glitter
- Glycerin (helps the sparkles fall more slowly)
- Liquid dish soap or hand soap - colorless works best

Instructions:

- Take the jar and fill it 3/4th of the way full with warm water
- Add glycerin almost to the top of the jar
- Put in around four small drops of liquid soap
- Put the lid on tightly and shake the jar
- When the water is calm, that is your mind when you are calm. Take some glitter and put it in a jar depending on what your thought is. For example, you can use red glitter for an angry thought you have or purple for a fearful thought you have. Only do one thought as a time and share with the group. Every group member will take turns sharing.
- When all group members are done adding thoughts, put the lid back on tightly.
- Turn the jar up and down 5-6 times
- You can now all see all the sparkles spinning around. This is your mind when you are upset.
- Put the jar down on the table and breathe in and out slowly. Only focus on the sparkles.
- As the sparkles are calming down, let your mind and angry thoughts calm down too.
- Save the jar and use it for the next time you get angry.
Session 7: Stress

Objectives:

- Assess anxiety levels in the children

Interventions:

- Provide psychoeducation and normalize anxiety for children.
- Make stress balls as a coping strategy children can utilize when feeling anxious.

Materials:

- Flour
- Balloons
- Funnel

Talking Points:

- Begin the discussion by asking the children if they understand what anxiety is. Explain that it is a feeling they sometimes get in their stomach, and can feel like butterflies in their stomach. Ask children to provide examples of times anxiety has affected them.
- Ask exception questions: is there a time when they didn’t feel anxiety? Or where they felt anxiety, but were able to overcome it. For instance, were they anxious about going to school, but went and had a great day? And if so, how were they able to make themselves go?
- Review coping strategies covered in group thus far.
- Introduce stress balls. “Today you are going to learn another coping skill you can use when you are feeling anxious. This can also help when you are angry too. We are going to be making stress balls!”
- SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.
Stress Balls

What you will need:

- Flour
- Balloons
- Funnel

Purpose:

The stress ball will serve as a tool you can use when you are feeling angry or stressed. It is really simple to make, but takes some time!

First:

Choose any color balloon and stretch it out. Be careful not to rip it.

Second:

Hold the balloon and insert the tunnel into the opening. Be sure the opening is completely sealed around the funnel and hold the balloon.

Third:

Add flour. When the balloon seems filled, hold the balloon by the skinny part and push the flour inside the balloon down on the table. This will allow for more flour to be placed inside the balloon.

Finally:

When the balloon is filled enough, push all the flour down inside the balloon and tie it up. You now have a stress ball you can use.

Note: You can also use rice, beans, or sand instead of flour.
Session 8: Conflict Resolution

Objective:

• Explore anger and the way it manifests itself in the children’s daily life.
• Explore current conflict resolution strategies and replace them with better techniques.

Interventions:

• Create a safe environment and use Socratic questioning to elicit a conversation about conflict resolution.
• Through the use of play therapy, use puppets to engage children in role plays that elicit conflict resolution skills.

Materials:

• Puppets

Talking Points:

• Can anyone tell me what conflict is? Ask children to provide examples.
• Ask for examples when they have been able to avoid engaging in arguments at home. Generalize positive attributes to other aspects of the children’s lives. Ex: “Wow, I wonder if not fighting at home has helped you walk away from arguments at school”
• Provide examples where children can discuss how they would resolve the issues. Ex: If someone came up to one of the children and made fun of their sweater, how would they handle it?”
• Use puppets to encourage role-playing of both positive and negative ways of handling conflict.
• SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.
Session 9: Self-Esteem

Objective:

• Increase positive self-image.

Interventions:

• Use art therapy to encourage children to engage in positive self-talk and identify positive attributes.

• Challenge any cognitive distortions the child may express during the art activity.

Materials:

• Colored Pencils/ Markers

• Paper/Construction Paper (3 per person)

Talking Points:

• Once the children have written or drawn on their paper, ask each child to share their drawings beginning with how the world sees them. Challenge any cognitive distortions.

• Encourage children to share how they see themselves.

• Go around the group and ask children to share how they would like the world to see them. Then ask other members to share positive characteristics they have noticed in the child.

• SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.
Example of Session 9 Activity

How I See Myself

• Funny
• Smart
• Good at Math
• Nice
• Silly
• Good at Soccer

How The World Sees Me

• Scared
• Little
• Nice
• Good at Math
• Quiet
• Lonely

How I Want The World To See Me

• Strong
• Friendly
• Smart
• Good at sports
• Funny
• Nice
Session 10: Maintenance & Termination

Objective:
- Explore feelings regarding the termination of group and explore ways in which children can maintain coping strategies established throughout the group process.
- Review safety plan.
- Assess reduction in trauma symptoms since the beginning of the group.

Interventions:
- Create a safe environment and use Socratic questioning to elicit a conversation about the group experience.
- Assign children to complete the TSCC.
- Create a take-away children can keep to remember the group by. Using “Journey Butterflies” from A Windows Between World and the accompanying poem, discuss the growth seen in the individuals.

Materials:
- Shrinky-dinks- cut into squares prior to session beginning.
- Butterfly templates
- Colored pencils- make sure they are sharpened
- Sharpies
- Brown paper bag
- Toaster oven
- The Hungry Hungry Caterpillar

Talking Points:
- How has this group been for everyone?
- Is anyone either really happy or really sad to be leaving the group?
- Can anyone tell me some of the things we learned? What about some coping skills we learned?
- Who can tell me something about safety? Review safety plan with children.
- After reading the book, “Can anyone tell me what that poem was about? How did it make you feel?”
- SUDS: “On a scale of 0-10, how nervous are you? 0 being not nervous at all and 10 being extremely nervous” If the scale exceeds 6, begin the session with controlled breathing.

Activity: Counselors should read The Hungry Hungry Caterpillar prior to beginning the activity.
JOURNEY BUTTERFLIES

Materials:
- Shrinky-dinks
- Sharpies
- Colored Pencils
- Butterfly template
- Hole Puncher
- Scissors
- Toaster Oven

Instructions:
- Choose from one of the butterfly templates and trace it or draw your own butterfly on the shrinky-dink.
- If using sharpies, you can use either side of the shrink-dink. If using colored pencils, use the rough side of the shrink-dink.
- Begin to color and create a design that will fill up your butterfly.
- When you are done coloring, cut out the butterfly with scissors.
- Use the hole punch to punch a hole in the butterfly. You can use this as a keychain or as a necklace.
- Place the Shrinky-Dink on a brown piece of paper (cut up a paper bag) and place it on a metal tray inside the toaster oven.
- Bake at 300 degrees until the Shrinky-Dink is completely flat (takes about one minute).
- Take the butterfly out of the oven and allow it to cool.
- If you wish to change the wings, you can do it while it is still warm.
Survey

On a scale of 1-4, please let us know how true the following statements are.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never true</td>
<td>Almost never true</td>
<td>Sometimes True</td>
<td>True</td>
<td>Always True</td>
</tr>
</tbody>
</table>

1. I found the group helpful
2. I have learned to manage my anger better
3. I have learned to handle my anxiety better
4. I have learned to handle my sadness better
5. I have learned a lot about violence
6. I have met some cool/nice people here
7. There are good things about me
8. I think I am a good person
9. I know how to stay safe
10. I know what to do if I ever see violence
SAMPLE: A CERTIFICATE SHOULD BE CREATED SPECIFIC TO THE AGENCY USING THE GROUP CURRICULUM

This certificate is to certify that [Name] has completed the 10 week support group at [Location].

Facilitator [Signature] 
Supervisor [Signature] 
Date [Date]
References


