

Assisting children affected by parental separation
and exposure to parental conflict.

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Abstract.

There has been some evidence to support the use of Trauma-Focused Cognitive Behavioural Therapies (TF-CBT) in children who have experienced sexual assault, traumatic grief, physical abuse or an array of single incident traumas. To the author's knowledge, there has been no research examining the efficacy of CBT in treating post-traumatic stress disorder (PTSD) symptoms following a conflictual parental separation. The study described in this thesis examined the efficacy of a 7-week TF-CBT program ($n = 15$) in comparison to a Bibliotherapy control group ($n = 14$), where parents received a self-help handbook. The TF-CBT condition involved a combination of individual child therapy sessions, group child therapy, and one parent of each child took part in a concurrent parent group session. Assessments were taken at intake in to the program, following treatment (or following reading of the book), and at a three-month follow-up session. Several hypotheses were tested: 1. It was hypothesised that children taking part in the CBT program would show significantly better improvement over children taking part in the Bibliotherapy condition, on measures of PTSD, depression, anxiety, perceptions of interparental conflict, internalising behaviour, externalising behaviour, feelings of being sad/depressed and feelings of being happy/content, from intake to post-treatment assessment. 2. It was hypothesised that these therapeutic gains made by children taking part in the CBT program, would be maintained at a three-month follow-up assessment. 3. It was further hypothesised that therapeutic gains observed in children taking part in the CBT condition, would not only be of statistical significance, but of clinical significance also. 4. It was hypothesised that parental ratings of happiness with their relationship with their child, would be related to more positive outcomes at post and three-month follow-up assessments. 5. It was hypothesised that children from conflictual parental separation, would be significantly worse at accurately identifying facial emotions on the Pictured Feelings Instrument, in comparison to the normative sample statistics reported in the Pictured Feelings Instrument manual (Schack Stone, 2004). Findings indicated that the TF-CBT condition was significantly better at ameliorating symptoms than the Bibliotherapy condition, on several main outcome measures. However, reoccurring parental conflict had an unwanted influence on results at follow-up assessment, indicating that children showing fear symptoms following conflictual parental separation require continued support in the face of new interparental conflict.

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For my son, Julian.

Declaration.

I hereby declare that this thesis contains no material which has been accepted for the award to the candidate of any other degree or diploma, except where due reference is made in the text of the thesis; to the best of the candidates knowledge contains no material previously published or written by another person except where due reference is made in the text of the thesis; and where the work is based on joint research or publications, discloses the relative contributions of the respective workers or authors.

Signed by the candidate, Fallon Cook: _____

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Definition of Terms.

High level parental conflict: high level anger and/or distrust between the parents coupled with verbal and sometimes physical aggression as well as problems communicating about their children and problems agreeing on the care of the children and possible sabotaging of the relationship between the child and the other parent (Johnston, 1998).

Trauma: any event that involves threat of injury or harm to either the self or any other person, that invokes fear, helplessness, disorganised and/or agitated behaviour (adapted from the DSM – IV – TR; American Psychiatric Association, 2000).

PAS: Parental Alienation Syndrome

PTSD: Post Traumatic Stress Disorder

PTSS: Post Traumatic Stress Symptoms

ASD: Acute Stress Disorder

SIT: Stress Inoculation Training

ANOVA: Analysis of Variance

Chapter 1: Prologue.

1.1. Introduction

Parental separation and divorce are a common phenomenon in Australia, with almost 50% of divorces between adults involving children under the age of 18 (ABS, 2008). In addition, a large proportion of these children witness some form of conflict between their parents throughout this time (Trewin, 2005). Evidence suggests that conflictual parental separation and divorce could constitute an event stressful enough to be considered a source of trauma for the children involved (Graham-Bermann, et. al., 2008; Weiss, 2001). Children who have been through a highly conflictual parental separation or divorce are at increased risk of poor psychological and social outcomes (El-Sheikh & Harger, 2001; Kerig, 1999, 2001; McLanahan, 1999; Stadelmann, Perren, Groeben & von Klitzing, 2010; Strohschein, 2005; Weir, 2006).

The impact that psychological trauma can have on a child both immediately and throughout the lifespan can be debilitating, particularly if symptoms of psychopathology are left untreated (Cohen, et. al., 2000). Disorders such as Post Traumatic Stress Disorder (PTSD) and depression are both common and often co-morbid (Famularo et. al., 1996). Factors known to aid child adjustment following a conflictual parental separation or divorce include reduced conflict frequency and intensity (Johnston et. al., 1987) and increased conflict resolution (Cummings et. al., 1989; Cummings & Davies, 1994). Children also benefit from having a close, positive, warm and communicative relationship with at least one parent (O'Connor, 2003; Hetherington & Stanley-Hagan, 1999; Rushena, Prior, Sanson & Smart, 2005; Wallerstein & Kelly, 1980). Such factors might be easily incorporated in to a treatment program for these children; however, no research to date has done this. Other research has examined the use of Cognitive Behavioural Therapy (CBT) in the treatment of post traumatic stress symptoms following trauma, with results indicating that this form of therapy is appropriate for use with children of sexual abuse (Cohen, Deblinger, Mannarino & Steer, 2004; Cohen & Mannarino, 1996, 1998a, 1998b; Cohen, Mannarino & Knudsen, 2005; Deblinger, Lippmann & Steer, 1996; Deblinger, Mannarino, Cohen & Steer, 2006; Deblinger, Stauffer & Steer, 2001; Deblinger, Steer & Lippmann, 1999; King, et. al., 2000),

childhood traumatic grief (Cohen, Mannarino & Knudsen, 2004b; Cohen, Mannarino & Staron, 2006b), witnessing of domestic violence (Tucker, 2010), child abuse (Feather & Ronan, 2006, 2009; Runyon, Deblinger & Schroeder, 2009) and varied single incident traumas (Morsette, et. al., 2009; Shooshtary, Panaghi & Moghadam, 2008; Smith, et. al., 2007). CBT is the most widely researched form of treatment for children showing post traumatic stress symptoms following a traumatic event. Whether this form of therapy can be successfully applied to children of other forms of trauma such as conflictual parental separation or divorce remains to be examined.

In addition to the plethora of negative psychological outcomes that children of trauma are at increased risk of, research examining the neural correlates of early traumatic experiences indicates that neural development may be significantly delayed in these children (Ito, Teicher, Glod & Ackerman, 1998). Further research carried out by the current author, found evidence that adults reporting childhood traumas exhibited significantly different neural connectivity than their non-traumatised counterparts (Cook, Ciorciari, Varker & Devilly, 2009). The authors speculated that such neural differences may relate in part to the increased prevalence of mental illness in adults reporting childhood traumas (Felitti et. al., 1998; Mulvihill, 2005). These findings led the current author to consider whether psychological therapies in childhood, provided directly following trauma, could lead to better long-term outcomes.

Chapter one will provide an overview of the aims and hypotheses addressed in this thesis, as well as a breakdown of the method employed in the testing of a CBT program designed to treat trauma symptoms in children who have been through a conflictual parental separation or divorce. Lastly, a description of the content that will be covered within each chapter of this thesis will be provided.

1.2. Project Aims

The current project aimed to examine the impact of a seven-week Cognitive Behavioural Therapy (CBT) program, in comparison to a ‘Bibliotherapy’ control group, for children showing fear reactions following a conflictual parental separation or divorce. Specifically, the aim was to examine whether symptoms of post-traumatic

stress, depression, anxiety, internalising behaviours and externalising behaviours could be ameliorated by the CBT program, and further, whether the CBT program was more efficacious at ameliorating symptoms than the Bibliotherapy condition. Levels of interparental conflict were measured, and parents gave ratings of how happy they were with the relationship they have with their child. The children were also tested on their recognition of emotive faces, as well as how often they experience specific emotions. These measures were taken over three time points - at intake in to the program, upon completion of the program (or completion of reading the book, dependent on condition) and at a three-month follow-up assessment. Specific hypotheses included:

1. That children taking part in the CBT program would show significantly better improvement over children taking part in the Bibliotherapy condition, on measures of PTSD, depression, anxiety, perceptions of interparental conflict, internalising behaviour, externalising behaviour, feelings of being sad/depressed and feelings of being happy/content from intake to post-treatment assessment.
2. That these therapeutic gains made by children taking part in the CBT program, would be maintained at the three-month follow-up assessment.
3. That therapeutic gains observed in children taking part in the CBT condition, would not only be of statistical significance, but of clinical significance also.
4. That parental ratings of happiness with their relationship with their child, would be related to more positive outcomes at post and three-month follow-up assessments.
5. It was hypothesised that children from conflictual parental separation, would be significantly worse at accurately identifying facial emotions on the Pictured Feelings Instrument, in comparison to the normative sample statistics reported in the Pictured Feelings Instrument manual (Schack Stone, 2004).

1.3. Overview of Method

Separated parents interested in taking part in the program completed an initial screening instrument to ensure their family's suitability to the program. All families then attended the Brain Sciences Institute at Swinburne University of Technology (Melbourne, Australia), to complete an intake assessment package. The parents completed their assessment questionnaires independently while their children completed an assessment one – on-one with a trained therapist. Families were then allocated to either the Bibliotherapy control condition ($n = 14$ children), in which case they received the book *‘Mom’s House, Dad’s House’* to take away and read, or to the seven-week therapy program ($n = 15$ children). Following completion of the therapy, or after an equivalent seven-week period for the Bibliotherapy participants, the families attended a post treatment assessment. After a 12 week period, families returned one final time for their follow up assessment. This method is described in further detail in Chapter 6.3.2. Assessment data was then entered and analyses were carried out, comparing main outcome measures between groups and across time points.

1.4. Summary of Chapter Content

This thesis will be broken down into the following chapters. Chapter two will discuss the prevalence of separation and divorce in Australia as well as the factors that predict separation and divorce, the impact that separation and divorce can have on the children involved as well as the impact that high level interparental conflict can have on children, followed by a description of the impact of separation and divorce on the parents. Chapter three will examine rates of trauma occurrence in children as well as the most common forms of childhood trauma, before introducing conflictual parental separation and divorce as a form of trauma. The factors that are thought to predispose children to psychiatric illness following trauma will be discussed, with a detailed description of the diagnostic criteria of several illnesses that may eventuate following a trauma. Chapter four will provide a detailed account of the factors known to impede or enhance a child's adjustment following parental separation or divorce, before describing how these factors may be considered when establishing CBT treatment methods for these children. The cognitive behavioural explanation of children's reactions to interparental conflict will

also be mentioned here. Following this, Chapter five will describe specific components of CBT that have been utilised in the treatment of children following a trauma, such as cognitive therapy, Stress Inoculation Training (SIT), exposure techniques and systematic desensitisation, before critically reviewing prior research that has tested the efficacy of such techniques in samples of children from varying trauma backgrounds. Chapter five will also include a critique of several programs that have been designed to prevent negative outcomes in children of separation and divorce, before critically reviewing assessment techniques and measures that might be used in a clinical or research setting with children who have been through a traumatic experience. Chapter six will introduce the current study that forms the central focus of this thesis, with full detail of the method employed, description of results, followed by discussion and interpretation of the findings.

Chapter 2: Parental separation and divorce and its impact on the child and parents.

2.1. Introduction.

Separation and divorce occurs quite commonly in Australia, with almost half of all divorces involving children (ABS, 2008). The effect of parental separation and divorce on the child can involve a myriad of negative psychological and physical health outcomes. Chapter two will first describe statistics regarding the prevalence of divorce as well as factors that predict divorce. A comprehensive review of the impact of parental separation and divorce and high level interparental conflict on the child will follow, with discussion of gender and age differences, and the phenomenon of Parental Alienation Syndrome. Many aspects of poor child psychological outcomes following marital dissolution are similar to those displayed by children who have undergone a traumatic event. This chapter will highlight these links and build an argument for the inclusion of high conflict parental separation as a form of childhood trauma. Two theories that attempt to explain the mechanisms underlying poor child outcomes following divorce will be described. Lastly, the impact of separation and divorce on the adult will be detailed.

2.2. The prevalence of separation and divorce in Australia and factors that predict marital dissolution.

Rates of divorce in Australia are relatively high, with 47,963 divorces granted in 2007, equating to 2.3 divorces per 1000 of the resident population (ABS, 2008). Children under the age of 18 years were involved in 49.3% of these divorces, with the average number of children per divorce (excluding divorces not involving children) equating to 1.88 (ABS, 2008). The median length of time from marriage to divorce was 12.5 years, with the majority of divorces being applied for by females (18,571), followed by joint applications (16,172), and males (13,216), although joint applications are reportedly on the rise (ABS, 2008).

Since 1988, the number of divorces rose steadily until 2001, and since this time has shown a steady decrease, for reasons unclear. Figure 1 demonstrates this trend.

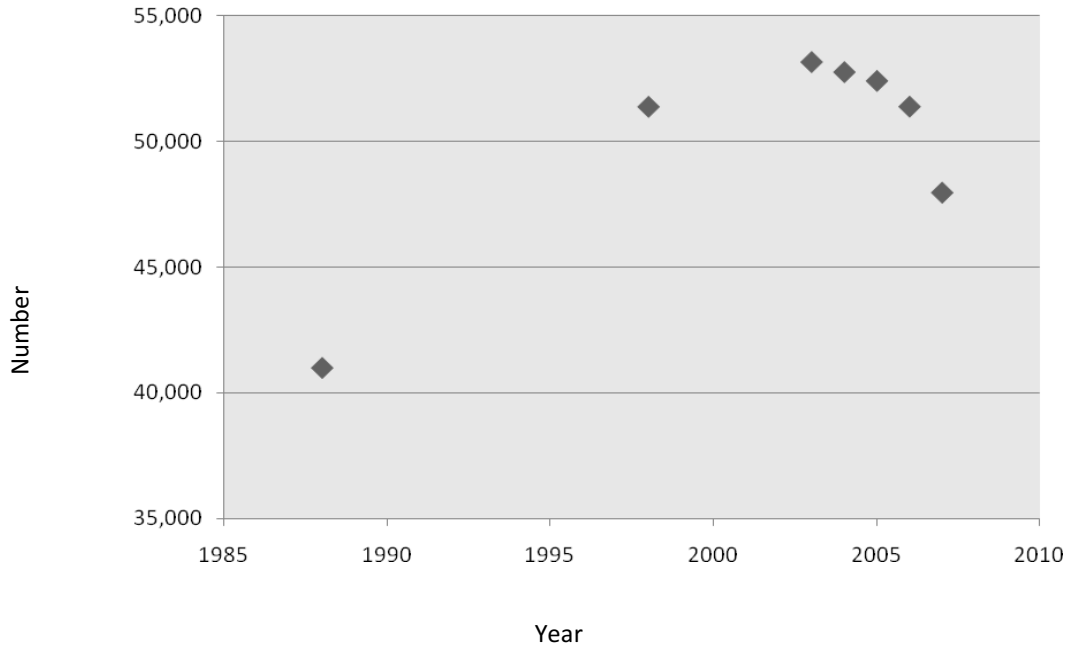


Figure 1. Divorces granted in Australia between 1988 and 2007.

Source: Australian Bureau of Statistics (ABS)

Fortunately, the number of children involved in divorces has been declining over the past 20 years although this trend has slowed recently. In 2007, 44,371 children across Australia were affected by divorce (refer to Figure 2.).

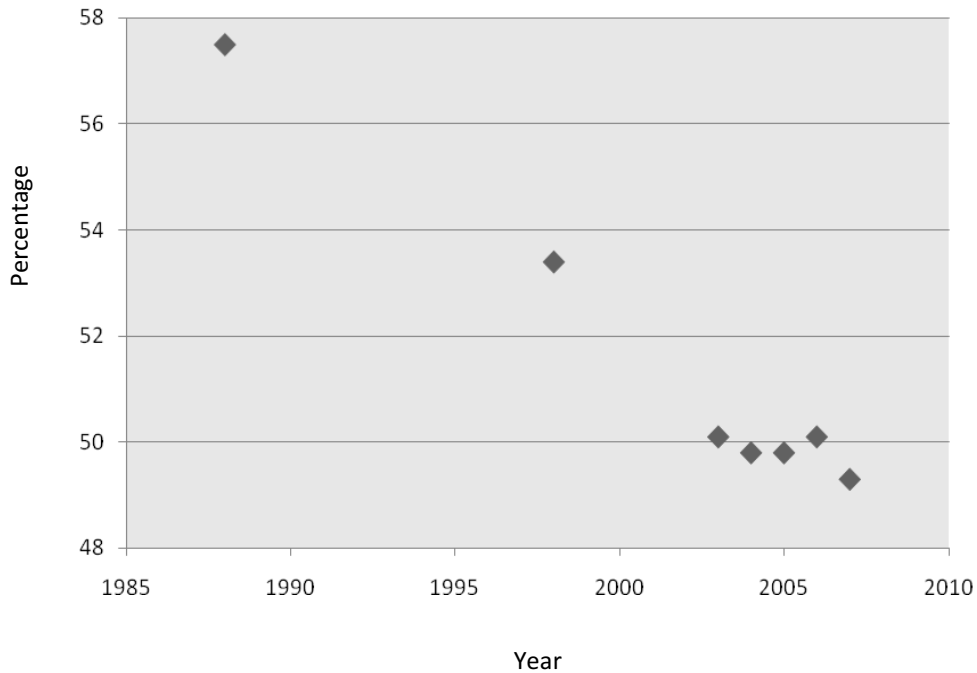


Figure 2. Percentage of Australian divorces involving children between 1988 and 2007.
Source: Australian Bureau of Statistics (ABS)

Overall, results indicate that a considerable number of Australian children each year experience parental marital dissolution. What remains more difficult to discern, are the exact numbers of these children that bear witness to interparental high level conflict throughout and beyond marital dissolution.

Factors that predict marital dissolution.

Given that almost half of all divorces in Australia involve children under the age of 18, it is important to consider what factors are associated with an increased risk of marital dissolution. Factors that are known to place relationships under increased stress, such as being unemployed, poor, and having lower education are associated with an increased risk of divorce, as are other factors such as marrying young, having a child prior to marriage, being in a second or subsequent marriage, or bringing children from a past marriage in to a new one (Bramlett & Mosher, 2002; Sweeney & Phillips, 2004; Teachman, 2002). Couples living under these circumstances may have increased

opportunity for conflict given the added stress from decisions to be made surrounding financial issues and the management of children. Other more obvious factors that predict divorce include decreased love between the partners, higher reported interpersonal problems, conflict, violence and having a lower level of commitment to the marriage (Clements, Stanley & Markman, 2004; Gottman & Levenson, 2000; Orbuch et. al., 2002; Previti & Amato, 2004).

There has been considerable controversy surrounding the impact of partners living together prior to marriage, and its causal impact on divorce. Evidence shows that cohabitation leads to increased risk of divorce particularly when it involves having a child prior to marriage (Tach & Halpern-Meeekin, 2009). It has been suggested that the increased tendency for couples who live together prior to marriage, to divorce, is due to them marrying due to the pressures and commitments that surmount during cohabitation i.e. sharing children, pets, vehicles etc. Perhaps these couples would not have married in the first place if they lived apart and did not have a vested interest in maintaining the relationship (Stanley, Rhoades & Markman, 2006). Evidence supports this proposed theory, with two studies showing that those who commit to marriage (become engaged) prior to living together, have more stable marriages (Brown, 2004; Rhoades, Stanley & Markman, 2009). It would seem that those who make a commitment to their relationship in the absence of the shared responsibilities and interests that are associated with cohabitation, are better placed to have longer lasting marriages.

The chances of divorce are increased when a partner perceives that the sharing of household jobs is unequal, as this is likely to increase conflict or animosity (Frisco & Williams, 2003). An important study (Amato & Hohmann-Marriot, 2007) analysing couples who divorced between two surveys, found that two groups could be distinguished that reported quite different relationship characteristics. The first group had high ratings of aggression, regular arguments and less marital happiness, and the second reported low rates of aggression, a small number of arguments and moderate marital happiness. These findings indicate that not all divorces eventuate due to the same set of dysfunctions, but other factors are in play that have yet to be identified.

2.3. The impact of parental separation and divorce on the child

The impact of parental separation and divorce on the child is not best documented by examining only correlational data between conflict and child outcomes, but rather, by considering parental separation and divorce as a multifaceted event with the potential to impact on domains surrounding child trauma, learning and development, family relations and cognitive skills (McIntosh, 2003).

There is evidence that societal opinion surrounding the well-being of children, places a higher level of importance on the *absence* of parental conflict on child well-being, rather than on marital status of parents (Woosley, Dennis, Robertson & Goldstein, 2009). Woosley and colleagues (2009) asked 31 adults to rate the perceived well-being of the children involved in four hypothetical scenarios. All scenarios involved two parents with two children. In the first scenario, the parents were married with no conflict, in the second they were married but experienced conflict, in the third they were divorced with no conflict, and in the fourth they were divorced and experienced conflict. Results indicated that child well-being was perceived to be significantly lower when parental conflict was apparent. These findings are in keeping with evidence that suggests that level of conflict, rather than marital status, has a higher impact on child well-being than does the actual dissolution of a marriage. As has been described by Amato (2000), the dissolution of a marriage may occur over many years, with the impact of the actual legal proceedings of the divorce on the child being rather insignificant in comparison to the vast life changes that the child is subject to. It is likely the short and longer term stressors surrounding these life disruptions that results in children of divorce having a higher risk of emotional, behavioural, interpersonal and academic problems, rather than the actual marital status of their parents (Amato, 2000). It has been suggested that marital conflict acts as a mediator of the effect of divorce on the child, and that when children can adjust quickly to divorce, they will experience fewer long term negative outcomes, with the opposite (longer time taken to adjust resulting in increased long term negative outcomes) also being true (Amato, 2010).

Some of the life disruptions likely to be experienced by children throughout the divorce process include potentially having to change to a new school, experience lower standards of living (often the financial situation of the resident parent is reduced when

the now non-resident parent leaves), increasing difficulties maintaining contact with the non-resident parent as well as extended family and relatives, and possibly having to become accustomed to new relationships within their home (Weir, 2006). Some of the factors known to have a negative impact on child well-being following divorce include: a decline in household income and standard of living, reduced contact with the non-residential parent, ongoing parental conflict, ineffective or non-cooperative co-parenting and reduced mental health of the residential parent (Carlson & Corcoran, 2001; Cavanagh, 2008; King & Sobolewski, 2006; Martinez & Forgatch, 2002; Tein, Sandler & Zautra, 2000).

When examining the impact of divorce on the child, prior research has tended to either examine the characteristics of children from divorce in general, or, the characteristics of children from marital conflict (which most often has resulted in divorce). Given that in some instances, divorce is actually an impetus for positive change for both the children and parents, and does sometimes result in more positive outcomes (Greeff & Van Der Merwe, 2004; Hetherington, 2003; Kelly & Emery, 2003; Rushena, Prior, Sanson, & Smart, 2005; this will be discussed further toward the end of section 2.3), it is important that we consider these different bodies of research separately, and with an element of caution. I will first present findings relating to the well-being of children from divorce in general, where the level of conflict between parents was not a delimiting variable.

Children of divorce, compared to those of intact families, are more likely to have health, social and economic problems (McLanahan, 1999), are more than twice as likely to require psychological treatment of some form (Johnston, 1997), are more likely to themselves use, and be part of social groups who use alcohol, cigarettes and drugs (McLanahan, 1999), are more likely to marry early and are also more likely to themselves divorce (Funder, 1996; McLanahan & Sandefur, 1994), are more likely to leave school prior to completion (Buchanan & Heiges, 2001) and give birth during their teenage years (McLanahan, 1999), and are also more likely to be of lower socio-economic status (Funder, 1996). Others have found that children of divorce fair worse in terms of their physiological development (when paired with being socioeconomically disadvantaged; Shaw & Emery, 1987) are more likely to have behavioural, emotional and academic disturbance, problems coping with people and the work place, as well as their own relationship difficulties in the longer term (Weir, 2006). School aged children

of divorce are also at increased risk of poorer cognitive performance (Fergusson, Lynsky & Horwood, 1994). Of concern is the finding that many of these differences between children from divorced and intact families, seem to become more apparent particularly in adolescence and in to adulthood (Cherlin, Chase-Lansdale & McRae, 1998). Adult children of divorced parents have an increased tendency to be of poorer psychological health, to be less educated, experience feelings of being less close to their parents, report increased problems in their own marriages and are more likely to become divorced themselves (Amato & Sobolewski, 2001; Barrett & Turner, 2005; Teachman, 2002; Wolfinger, Kowaleski-Jones & Smith, 2003).

Although parental divorce or separation might be considered a difficult event for a child to endure, it is the level of conflict between the parents throughout the divorce or separation that is most predictive of child outcomes (Kelly, 2000). Rather than comparing the outcomes of children from divorce or separation versus those from intact families, it is important to examine those children who are exposed to enduring conflict. Not all parental separations or divorces are conflictual. Acknowledging and understanding the varied outcomes of children from high conflict marital dissolution helps to inform clinicians of the typical presentation of a child who might not be adjusting effectively to their new circumstances.

First of all it is important to define parental conflict. Johnston (1998) describes entrenched parental conflict as involving high level anger and/or distrust between the parents coupled with verbal and sometimes physical aggression as well as problems communicating about their children and problems agreeing on the care of the children and possible sabotaging of the relationship between the child and the other parent. These behaviours often continue for some time after parental separation or divorce and this behaviour is associated with increased occurrence of litigation (McIntosh, 2003). Parental conflict has a greater adverse impact on the child when there is no resolution to the conflict, when physical violence is present, when hostility between parents is high and when parents make threats to leave (Margolin, Oliver & Medina, 2001).

Weir (2006) described some of the distinguishing features of children exposed to high level conflict, in a paper designed to provide guidance to clinicians who regularly deal with legal cases surrounding child living arrangements and visitation rights following

conflictual parental separation or divorce. Weir describes younger children as typically having increased anxiety levels, particularly when transferring from the care of one parent to the other (a time when conflict is more likely to occur). Some children will have increased aggression and hostility towards others as well as conduct problems, or to the contrary, may become overly concerned with pleasing adults, are unable to relax and may actually be disliked by other children for this behaviour. Children of high level conflict may become secretive and distrusting of adults and peers and behave in ways that are manipulative. In addition, there is a tendency for these children to exaggerate their version of events when speaking with one parent in order to get a positive response from that parent (i.e. telling their mother that they dislike going to their father's house, when in fact, they quite enjoy their time there; Weir, 2006). Other evidence suggests that children exposed to high level parental conflict have increased levels of self blame, exhibit increased internalising and externalising behaviours and report more health problems (El-Sheikh & Harger, 2001). When children attempt to intervene and end the conflict between their parents, they are more likely to report higher levels of anxiety and depression (Kerig, 1999, 2001). In addition, children exposed to violent conflict between their parents are more likely as adults, to be dissatisfied with their lives, have low self esteem, be more prone to psychological distress and have increased violence in their own relationships (Amato, 1999). Importantly, Ayoub and colleagues (Ayoub, Deutsch & Maraganore, 1999) write that a single incident of violence between parents is enough to be classified as a *trauma* of diagnostic significance. Many of the negative outcomes associated with parental conflict that are reported here, are in fact similar to the symptoms displayed by children who have undergone other forms of trauma. This will be discussed further in Chapter three.

Throughout childhood, children reach certain milestones in development, some of which have been suggested to be at risk of not being achieved when the child is exposed to high level conflict between parents. Crockenberg and Langrock (2001) write that these milestones include: the development of trust and an understanding of the link between cause and effect, the development of healthy and secure attachment to parents, the ability to self regulate emotion and arousal, the development of beliefs about the self, the ability to create relationships with other children and the ability to function well at school. Ongoing parental conflict can provide such a poisonous environment for the child, that their psychological growth is compromised and developmental requirements

may not be met (Grych & Fincham, 2001; Kelly, 2000). It is a common view that the absolute foundation for healthy child psychological development rests on having a sound family environment coupled with emotionally responsive parenting (McIntosh, 2003). Importantly, when parental conflict occurs in proximity to other negative circumstances such as poverty, poor parental mental health or parental unemployment, the psychological effects of conflict on the child have been shown to be even more prominent (Crockenberg & Langrock, 2001; Dixon, Charles & Craddock, 1998).

The psychological impact of parental conflict on the child will depend somewhat upon the child's age. For example, it has been suggested that the impact of parental conflict and separation or divorce might be greatest during the preschool years when the child has the greatest number of developmental tasks, but the child's resources required for achieving these tasks may be lowered by the distraction of having to find ways to cope with ongoing conflict (Wallerstein & Lewis, 1998; Zill, Morrison & Coiro, 1993). When children are under the added pressure of having to live in an unpredictable emotional environment, their capacity for playing, learning and interacting with others will be reduced (Johnston, 1997). The inability to engage in these normal activities may be the impetus for poor development.

During the first few years of life, insecure and disorganised attachment styles are common when the child has been exposed to high level parental conflict (Boris & Zeanah, 1999; Main & Cassidy, 1998; Zeanah, et. al., 1999). This interruption to normal emotional security in the child can predispose the child to further distress, negative arousal and a reduced ability to effectively regulate their own emotions and behaviours, essentially making these children less able to cope with change (Leiberman & Van Horn 1998).

When children experience parental conflict at around the age of five years, they are more likely to blame themselves for the parental conflict, given that they often cannot yet conceptualise their parents as having roles outside of parenting - that is, if the fight is about parenting, then the fight must be about me (Jenkins & Buccioni, 2000). It is not until around the age of seven that children have the capacity to understand the conflict in terms of their parents unique mental state, and can acknowledge that other factors are involved in the conflict outside of just parenting (McIntosh, 2003).

Gender differences exist in the way a child will react to parental conflict. Boys are more likely to become angry and perceive the situation as increasingly threatening, as well as being more likely to report greater externalising symptoms and increased anxiety, whereas girls have higher perceptions of self blame and report more internalising symptoms (Cummings, Davies & Simpson, 1994; Kerig, 1998). These responses to conflict might become entrenched behaviours that influence the way that child reacts to other situations and future conflict in their own lives (Davies & Lindsay, 2001). It has been suggested that this may have the longer term impact of the child having poor ability to emotionally self regulate (Jouriles, Bourg & Farris, 1991), which can involve increased aggression, anxiety, poor social skills and dysfunctional behaviour patterns (Block, Block & Gjerde, 1986; Cummings & Davies, 1994; Harrist & Ainslie, 1998; Johnston, Gonzalez & Campbell, 1987).

A child's ability to cope through parental conflict might be assisted through increased parental soothing, increased resolution of conflict and discussion between the parent and child about the events and emotions that occur during the conflict (McIntosh, 2003). It is when these behaviours are not apparent that children are increasingly likely to proceed on a more negative developmental trajectory.

The term Parental Alienation Syndrome (PAS), was first described by Gardner (1998) and describes a condition that is unique to cases of marital dissolution that are characterised by conflict surrounding custody, care and visitation rights over the involved children. Cases of PAS are reportedly common (Weir, 2006). PAS involves the child becoming alienated from one parent, due to the residential parent deliberately turning the child against the non-resident parent. The child will typically respond by joining in with the condemnation of the non-residential parent, will have poor rationalisations for the condemnation, will tend to see their parents in only black and white terms (i.e. the residential parent is perfect in all possible ways while the non-residential parent is considered to be entirely bad), the child will often claim that their opinions are entirely their own and will not experience any guilt about their behaviour, support for the resident parent is often automated and the child will actively share their animosity toward the non-resident parent with others and lastly, the child's complaints often sound rehearsed and use adult language that seems to be a repeat of what the child

has heard the residential parent say (Weir, 2006). The child's animosity towards the non-residential parent quite often has no real basis, hence the child's inability to explain why they feel that way about the non-residential parent. Rather, the animosity stems from the child receiving positive attention from the resident parent when they elicit the same views as the resident parent.

The possibility of PAS occurring in children of conflictual parental separation and divorce is an important consideration for those working in the legal system (PAS is recognised by the courts of England and Wales according to Weir, 2006), where child accounts of their circumstances and preferences for future care and contact with non-residential parents may be severely biased. Consideration of this syndrome is also important when working with such children in a research context, as psychological measures taken from these children may be unintentionally biased or exaggerated and may be easily susceptible to influence from the resident parent particularly during episodes of ongoing conflict (Lee & Olesen, 2001; Crossman, Powell, Principe & Ceci, 2002).

Several high quality research studies of sound design have been carried out in an attempt to further describe the impact of parental separation and divorce on the child. Three of these studies are described below.

Stadelmann, Perren, Groeben and von Klitzing (2010), carried out a thorough longitudinal study examining the effect of parental separation or divorce and levels of interparental conflict, on behavioural and emotional problems in kindergarten children. One hundred and eighty seven children took part in the study, and were each assessed at five and then six years of age. The parent and the child's kindergarten teacher completed the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) in order to assess the child for any emotional and/or behavioural problems, while the child completed the Berkeley Puppet Interview (BPI; Measelle, Ablow, Cowan & Cowan, 1998). Parents also completed the conflict subscale of the German version of the Family Environment Scale (Moos & Moos, 1981; Schneewind, Beckmann & Hecht-Jackl, 1985), as a means of measuring the level of conflict currently between the child's parents. Finally, the children completed the MacArthur Story - Stem Battery (MSSB; Bretherton & Oppenheim, 2003), a test whereby children are given a small part of a

story that involves some sort of dilemma, and the child's response to the dilemma is recorded. The narratives that the children expressed were then examined for any negative parental representations, and were scored yes/no according to whether one occurred or not. Findings indicated that while level of conflict and negative parental representations were not significantly correlated with each other, they were each significantly correlated with specific indices of behavioural and emotional problems. Higher family conflict levels were significantly related to increased conduct problems (Age 5: $r = .28, p < .01$; Age 6: $r = .28, p < .01$) and emotional problems (Age 5: $r = .27, p < .01$; Age 6: $r = .24, p < .01$). The occurrence of negative parental representations was positively correlated with increased conduct problems (Age 5: $r = .20, p < .05$; Age 6: $r = .15, p < .05$) and with increased hyperactivity (only at age 6: $r = .15, p < .01$). Findings indicated that parental separation, level of conflict and negative parental representations were all predictors of increased conduct problems at six years of age, with parental separation being the strongest predictor. These findings provide support for the view that early parental separation and parental conflict can have a negative psychological impact on children that may result in issues with child conduct.

Early studies of the effects of parental separation and divorce were largely of a cross sectional design that did not allow for measurement of aspects of family life prior to marital dissolution. Such aspects may shed some light on why some children cope well, and others poorly, and may indicate the specific aspects of family life that are responsible for poor outcomes in children. Strohschein (2005) conducted a large prospective study examining some 2819 Canadian children aged four to seven years of age, who were living with both biological parents at an initial interview. Child mental health was assessed at this initial interview and again four years later and comparisons were made between those children whose parents remained together, and those whose parents did not. Parents of the children completed the anxiety / depression and antisocial behaviour subscales of the Child Behaviour Checklist (Achenbach & Edelbrock, 1983), reported on household income for the previous year, and completed items regarding marital satisfaction, family dysfunction (McMaster Family Assessment Device; Byles, Byrne, Boyle & Offord, 1988) and parental depression (Center for Epidemiological Studies Depression Scale; Radloff, 1977). Results indicated that at the initial interview children whose parents would later divorce, were experiencing significantly higher anxiety and depression symptoms and higher rates of antisocial behaviour than those

whose parents remained together. This difference was still apparent at the follow up four years later when the parents had since divorced. Not surprisingly, at the initial interview, those parents who would later divorce, rated their marriages as significantly less satisfying, significantly more dysfunctional and had significantly higher levels of depression than those parents who continued on in intact marriages. These results indicate that child psychological well-being is already somewhat affected prior to parental separation or divorce. These children have a tendency to be exposed to a dysfunctional marriage (characterised by a reduction in emotionally satisfying relationships amongst family members) and have parents with poorer psychological health however, we cannot make assumptions regarding causation. One of the major limitations acknowledged by the authors is the lack of data collected regarding conflict levels and violence in the homes of these children. These factors would yield valuable information about specific stressors throughout marital dissolution that might act as mediators to child well-being throughout and following parental separation and divorce.

It is important to consider the impact of psychosocial well-being on child outcomes following divorce, given its impact on areas such as academic functioning (Lane, Carter, Pierson & Glaeser, 2006). Primary school aged children of divorced parents have been shown to exhibit poor psychosocial well-being in the year prior to divorce that persists for two years before recovering (Lansford, et. al., 2006). Additionally, levels of psychosocial well-being have been shown to be significantly lower in these children, in comparison to those children whose parents remained married (Lansford, et. al., 2006). Psychosocial health has a known role in child academic performance (Lane, Carter, Pierson & Glaeser, 2006). Given that children of divorce are also known to exhibit poorer academic achievement than children from intact marriages, Potter (2010) conducted research examining whether psychosocial health of children from divorced parents, has a role in their subsequent poorer academic achievement. A sample of 10,061 grade 5 children were randomly sampled in a stratified manner (first samples were drawn from schools, then from counties), with measures taken from the child, the parent, a teacher and school administrator. Data from these grade 5 children had been gathered previously during four waves – during kindergarten, grade 1, grade 2, grade 3 and grade 5. Psychosocial well-being was measured by collating reports from the teacher, parent and child on measures of internalising problems, externalising problems and social skills. Academic performance was measured by examining reading and

mathematical scores. Other measures examined the quantity of economic resources available to the family, parenting practices, levels of interparental conflict and parent-child relationship quality. Items used to assess each of these domains were designed specifically for this study and individual items are not described in the published manuscript due to a copyright embargo. Parental divorce was associated with a significant decline in psychosocial well-being. Academic performance was found to suffer immediately following divorce. Additionally, psychosocial well-being was found to explain the relationship between parental divorces and reduced academic performance- that is, reduction in academic performance was in part due to a reduction in psychosocial well-being. Unfortunately, internalising and externalising behaviour scores were not analysed separately in the study, but were instead collated to form the psychosocial well-being variable. Therefore, no direct conclusions can be drawn from this particular study about the impact of marital dissolution on these specific behavioural domains. Overall, this study indicates that children with higher levels of psychosocial well-being, who experience the separation or divorce of their parents, may have less of a decline in academic achievement. What we do not yet know, is whether the teaching of psychosocial skills to children of divorce, would help ameliorate this decline in academic achievement. This would be worthy of further investigation in treatment studies of children of divorce.

Several researchers have attempted to explain the mechanisms underlying poor child psychological outcomes following parental separation and divorce. Harris (1998) describes a ‘passive genetic model’ that describes the relationship between poor child outcomes and parental divorce as being rather spurious and instead due to genetically inherited characteristics. The model is based on the idea that parents who undergo divorce are genetically predisposed to traits that make them more likely to divorce- aggression or poor social skills could act as an example here. The model suggests that given children share 50% of their genes with each parent, they would have a reasonable chance of inheriting these same traits- traits that may strongly contribute to an increased incidence of conduct disorder, poor attachment to others, and in turn, increased depression and anxiety. Therefore, the theory suggests that the tendency for research to observe correlations between parental conflict and divorce and poor child outcomes, is due to the genetic characteristics of these children, rather than the outcomes being a product of the child’s circumstances. Although an interesting and novel approach, twin

studies have failed to find strong evidence for this theory. While some degree of the poor child outcomes following divorce might be attributable to genetics, the impact of genetics is likely only quite small.

Others (Capaldi & Patterson, 1991; Wu & Martinson, 1993) instead describe the tendency towards poor child outcomes following divorce to be less due to the actual divorce, and more due to the number of transitions required by the child throughout the divorce process. Divorce might be the impetus for a change in residence and/or school, the adjustment to a new relationship in the home, new marriages or divorces as well as a myriad of other changes to the child's normal routine. The theory suggests that a higher number of adjustments required by the child will result in poorer outcomes. An increased number of changes to family structure during childhood has been shown to be associated with poorer psychological well-being (Amato, 2003), poorer academic performance (Martinez & Forgatch, 2002), increased externalising behaviour (Fomby & Cherlin, 2007), and other behavioural problems (Cavanagh & Huston, 2006; Osborne & McLanahan, 2007), thereby providing support for this theory.

Resilience

While this thesis focuses predominantly on the negative psychological impact of highly conflictual marital dissolution on children, it would be remiss not to address the resilience that many children and adults show throughout divorce and into their adult lives. Divorce need not always be associated with negative outcomes. Divorce may be the impetus for a move away from abusive circumstances, the reduction of conflict and may be a step towards more positive relationships and personal growth (Hetherington, 2003). For example, while approximately 20-25% of children from divorced families or remarried families show clinically significant scores on behaviour measures on the Child Behavior Checklist (CBCL; Achenbach, 1991), so do around 10% of children from non-divorced families (McLanahan & Sandefur, 1994). As noted by Hetherington (2003), this means that somewhere in the vicinity of 75% to 80% of children from divorced families are functioning in a normal range. Many other studies have also found support showing that the large majority of children from divorce cope quite well (Greeff

& Van Der Merwe, 2004; Kelly & Emery, 2003; Rushena, Prior, Sanson, & Smart, 2005).

2.4. The impact of parental separation and divorce on the parent.

While the primary focus of this thesis is the impact of parental separation and divorce on children, it is important to also consider the impact of such events on the adult's involved. Firstly, it should also be acknowledged that some adults cope quite well through divorce, particularly when the marriage was very distressing (Amato & Hohmann-Marriot, 2007), or when the divorce was initiated by the adult (Williams & Dunne-Bryant, 2006). This is not always the case though and overall, adults who have been through a divorce tend to score higher on measures of anxiety and depression, have increased health problems and increased use of substances than those who remain married (Hughes & Waite, 2009; Lorenz, Wickrama, Conger & Elder, 2006; Zhang & Hayward, 2006). The decreased well-being experienced by adults of divorce, is likely due not only to the cascade of stressful events happening in the short period of time surrounding the divorce, but also due to the longer term persistent stressors as the individual adjusts to their new circumstances. Such longer term stressors may include adjustments surrounding the increased demands of being a single parent, a sudden decline in household income, sudden absence of a partner for support or perhaps reduced access to the children. Whether changes in adult well-being occur before, during or after divorce may depend on whether the divorce was actually wanted by the adult. While some have found that well-being is lowest in the years leading up to divorce (Hans-Jürgen & Bröckel, 2007), others have found that psychological well-being doesn't improve until adults remarry (Johnson & Wu, 2002), or that psychological distress increases directly following divorce with a later decline, with health problems most apparent ten years post divorce (Lorenz, Wickrama, Conger & Elder, 2006). Trajectories of adult well-being throughout the divorce period are likely to differ greatly depending on a wide range of personal circumstances, resources and supports available to the adult, however, most adults have adapted well to their new circumstances after several years (Amato, 2010).

Two main theories exist that attempt to explain the effect of divorce on poor adult well-being. The first theory is based on the idea that the divorce itself has a direct causal role in lowering adult well-being. That is, divorce is a stressful event that involves a large number of changes in the adult's life. These changes increase stress levels which in turn is known to lower mental and physical health (Pearlin, Schieman, Fazio & Meersman, 2005). Adults who undergo divorce also lose many of the advantages of being married, such as having company, assistance from the partner, additional support, and someone who is concerned about their mental and physical well-being. The other theory, suggests that poor adult well-being following divorce is spurious and due to selection factors rather than the divorce itself. That is, there is a tendency towards negative well-being in adults prior to divorce and this may actually act as an impetus for the divorce. There is some limited support for this theory (Brockmann & Klein, 2004), however, others have found no evidence even when controlling for all possible pre-divorce variables (Johnson & Wu, 2002). It is widely accepted that divorce itself can be responsible for a reduction in adult well-being, however, selection factors may play some minor role in these negative outcomes.

2.5. Summary

To summarise, parental separation and divorce can result in a multitude of negative outcomes for both the child and parents, particularly when high level interparental conflict is involved. Children of parental separation and divorce are at higher risk of experiencing conduct problems (Stadelmann, Perren, Groeben & von Klitzing, 2010), anxiety, depression, antisocial behaviour (Strohschien, 2005), and externalising behaviour problems (Fomby & Cherlin, 2007). The risk appears to be increased in those children who are exposed to a highly conflictual parental separation or divorce (Kelly, 2000), with some saying that just one incident of interparental violence, is enough to constitute a clinically significant traumatic event (Ayoub, Deutsch & Maraganore, 1999). The negative child psychological outcomes described within this chapter are indeed similar, if not identical, to the psychological outcomes observed following other forms of childhood trauma. There is evidence to suggest that in some instances, conflictual parental separation and divorce can act as a form of childhood trauma, and this idea will be further discussed in Chapter three.

Chapter 3: Childhood trauma and its consequences.

3.1. Introduction

Humans, like all mammals, have a hard wired and evolutionary adaptive response to stress, commonly referred to as the ‘fight-or-flight’ response, during which the body prepares itself to either fight a stressor or to flee or ‘fly’ from the situation (Cannon, 1915). The physiological changes associated with this response, such as an increased heart rate, increased muscle tension and faster breathing are designed to prepare the body so it is in an optimal state to increase chances of survival (Cannon, 1915). However, when a stressor is either very severe or prolonged, our resources to cope become depleted and our physical and psychological health will inevitably deteriorate (Selye, 1950). A stress response is a common reaction when a person undergoes a traumatic experience. For the purpose of this thesis, trauma will be defined as an event involving death, or the threat of death or serious harm to either the self or another person that results in extreme fear, helplessness, horror and/or disorganised behaviour (adapted from the DSM-IV-TR, American Psychiatric Association, 2000).

Childhood traumas have been linked to many differing psychopathologies both during childhood itself and extending well into adulthood (Bifulco et al. 1991; Brown et al. 1986), and have also been linked to altered neural connectivity in adulthood (Cook, Ciorciari, Varker & Devilly, 2009). The potential severity of psychological outcomes following a childhood trauma is extensive. Chapter three will first examine reported rates of trauma occurrence during childhood, and the types of trauma that children are most likely to be exposed to. Evidence will be provided and the argument will be made, that conflictual parental separation is a valid form of childhood trauma and will require treatment as such. Predisposing factors to psychiatric illness following trauma will be described, followed by a comprehensive review of child reactions following trauma, anxiety disorders that may result from trauma (including Posttraumatic Stress Disorder and Acute Stress Disorder) as well as depression.

3.2. Rates of trauma occurrence in children.

Exposure to a traumatic incident during childhood seems to be a far from uncommon experience (Costello et al, 2002). Unfortunately traumatic incidences, particularly those involving abuse from care-givers, can go unknown for many years until such time as the victim becomes an adult and has the opportunity to speak about their experience without fear of reprimand. Some reported statistics on trauma prevalence are based on adulthood self report measures (where the adult thinks back to their childhood and reports on how many traumatic incidences they were exposed to), and others use data obtained from children during childhood. It is these varied methods of data collection that make precise rates of childhood trauma difficult to ascertain.

Rates of childhood trauma appear to be much higher in inner-city samples. In a study of inner city youth (aged 7 to 18), 70% reported the occurrence of at least one trauma (Fitzpatrick & Boldizar, 1993), and in another study 59% of youth reported a trauma (Silva et al, 2000). Studies have also found gender differences in specific types of trauma reported. For example, physical abuse is more common in boys than in girls, but for sexual abuse the opposite is true, with three times the amount of sexual abuse reported for girls than boys (Australian Institute of Health and Welfare, 2008).

Often the occurrence of a childhood trauma goes unknown until much later on in life when the victim, now adult, seeks treatment for on-going complaints relating to the trauma. Precise statistics showing exact rates of trauma occurrence in the Australian population are unavailable as no specific, large-scale studies of the general population have been carried out. There are however statistics available regarding trauma occurrence in specific populations. For example, in a study of Sydney female street-based sex workers (Roxburgh, et. al., 2006), all but one of the 72 women participants reported at least one past trauma, with most reporting several instances of trauma. Most traumas began occurring in childhood, with childhood sexual assault being among the most prevalent. A study of homeless people in Australia (Taylor & Sharpe, 2008) also revealed a staggering rate of 98% of the study sample reporting the occurrence of a traumatic event in their lifetime. Mean age at time of trauma was 12.4 years ($SD = 9$) indicating that most traumas occurred during childhood (under the age of 16). While there is a lack of research that has comprehensively examined trauma occurrence in the

general population, the statistics we do have available are indicative that most people will undergo some form of traumatic event at some point.

3.3. Common types of childhood trauma

Commonly reported types of childhood trauma include personally experiencing an injury or accident, witnessing death or injury of others, and hearing news of a sudden death or accident (Giaconia, et. al., 1995). Childhood trauma can also take the form of physical abuse, sexual abuse, psychological/emotional abuse, or neglect (Australian Institute of Health and Welfare, 2008). Other forms of trauma might include bullying, being in proximity to natural disasters, or malnutrition. The DSM-IV-TR (American Psychiatric Association, 2000) gives no specific criteria for the types of events that can and cannot be considered traumatic; rather, it suggests that whether an event can be considered traumatic or not relies predominantly on the perception of the child who experiences it (American Psychiatric Association, 1994).

3.4. Conflictual Parental Separation and Divorce as a form of Trauma.

As described in Chapter two, in Australian society the prevalence of marriages ending in divorce is quite high. In 2007, some 47,963 divorces were granted, with 49.3% of these divorces involving children under the age of 18 (ABS, 2008). While not all marital breakdowns are conflictual, it is fair to assume that many are. In a report released by the Australian Institute of Family Studies (Wolcott & Hughes, 1999), 27.3% of surveyed divorcees believed the main reason for the divorce was due to communication problems, 21% to incompatibility, 20.1% to infidelity, 7.4% to alcohol or drug abuse, 5.5% to physical violence against either themselves or their children and 1.9% to emotional or verbal abuse. These statistics indicate that a reasonable proportion of children from divorced parents must experience or witness verbal conflict, physical violence against themselves or their parents, alcohol and drug abuse, and other forms of emotional and verbal abuse. Although a couple may divorce in order to end conflict, conflict may

continue for up to two years post divorce in 24-33% of divorced families (Moskowitz, 1998), and it appears that the degree of conflict and hostility between parents, rather than marital status, is more significantly associated with childhood illness (El-Sheikh, Harger, & Whitson, 2001). High level marital conflict has been correlated with physical stress, namely, increased heart rate and higher blood pressure (Cummings & Davies, 1994). Most researchers agree that children who live with high levels of marital conflict experience a higher degree of distress and anxiety issues (Sarrazin & Cyr, 2007). Several studies have found that the most common externalising symptoms following divorce include disruptive behaviours such as aggression, destructiveness and compliance disorders (Hetherington, 1991; Grych & Fincham, 1992). In addition, it is estimated that around two-thirds of divorced parents pressure their children to side with them in parental conflicts (Wallerstein & Kelly, 1980). This has been associated with an even higher level of psychological problems (Davis, Hops, Alpert & Sheeber, 1998), including increased feelings of anxiety (Buchanan, Maccoby, & Dornbusch, 1991). Research has also indicated a strong tendency for psychological well-being to be affected even into adulthood (Overall, Henry, & Woodward, 1974; McNeal & Amato, 1998). In a study of adolescents, Hetherington (1991) reported that 45% of those in remarried families, 30% of those in divorced families and 10% of those from intact families scored above the clinical cut-offs for the total behavioural problems subscale of the Child Behaviour Checklist (CBCL; Achenbach, 1991). This would indicate that those from separated families and particularly those whose parents remarry, are more vulnerable to psychopathologies than adolescents from intact families. However, such a relationship cannot be assumed to be causal. The overwhelming impact that divorce, and in particular, parental conflict that occurs throughout the divorce, can have on the child, indicates that divorce can be a source of major and potentially damaging distress.

There are several compelling reasons why high level interparental conflict might be considered a traumatic experience for the children involved. Firstly, the DSM-IV-TR (American Psychiatric Association, 2000) states that a traumatic event can be any event that involves threat of injury or harm to either the self or any other person, that invokes fear, helplessness, disorganised and/or agitated behaviour. It is entirely plausible that a young child who witnesses high level conflict, whether it be verbal or physical, would experience some degree of fear and a sense of helplessness, given that the situation is not within their control and they can see the immediate negative psychological harm

that the conflict is having on one or both parents. Interparental conflict throughout divorce is likely to include threats to leave by one parent, which to a young child who depends on both parents for care, may be understood as a threat to the very foundations required for them to meet their developmental needs. As outlined by Weiss (2001), if a child's sense of safety and trust in their surroundings is jeopardised and one parent is suddenly absent, feelings of abandonment may arise, which is significantly traumatic for a child. Conflictual parental separation or divorce may not be considered traumatic by an adolescent or an adult; given that they do not have the same level of dependence on their parents, and are not in the developmental process of forming secure attachments to their parents.

The DSM- IV-TR (American Psychiatric Association, 2000) also states that whether an event is considered traumatic or not is entirely open to the child's own perception of the event, and that the types of events that are considered traumatic may differ vastly between adults and children. Graham-Bermann and colleagues (Graham-Bermann, et. al., 2008) carried out an investigation of the specific types of events that are considered to be traumatic for preschool children. Results indicated that parents of preschool children classified high conflict marital separation and divorce as a traumatic event for children of that age. Additionally, those children who had been through a conflictual parental separation or divorce scored highly on measures of post traumatic stress symptoms (as measured by the Preschool Posttraumatic Stress Symptoms Inventory; Graham-Bermann, 2001), suggesting that this form of trauma may have the potential to result in Posttraumatic Stress Disorder (PTSD). Other researchers have also included the witnessing of domestic violence and verbal threatening as a type of trauma for young children (Ghosh-Ippen, et. al., 2002).

In addition, there are many similarities between the negative psychological outcomes for a child following a conflictual parental separation or divorce, and those of a child who has undergone another form of trauma. For example, children of conflictual parental separation and divorce are likely to report higher levels of anxiety (Weir, 2006; Kerig, 1999, 2001), depression (Kerig, 1999, 2001), internalising and externalising behaviours (El-Sheikh & Harger, 2001), increased aggression and conduct problems (Weir, 2006), and even posttraumatic stress symptoms (Graham-Bermann, et. al., 2008) all of which have also been found to occur in children who have been through other

types of trauma (Breslau, Davis, Andreski & Peterson, 1991; Creamer, Burgess & McFarlane, 2001; Kessler, Sonnega, Hughes & Nelson, 1995; Kilpatrick et. al., 2003; Stover & Berkowitz, 2005; Weir, 2006).

By no means are all cases of parental separation and divorce traumatic for the children involved, rather, cases that involve high level interparental conflict *may* be distressing enough for one or both parents and/or the child to perceive the event as being traumatic. In cases of high conflict, marital dissolution may actually serve to benefit the children involved (Amato, Loomis, & Booth, 1995), with a reduction in the child's exposure to conflict.

The focus of this thesis and the research project carried out and described in Chapter six, is primarily concerned with parental separation or divorce that has involved significant interparental conflict to which children display posttraumatic stress symptoms. That is, from this point forward, conflictual parental separation and divorce will be included and discussed as a form of childhood trauma.

3.5. Predispositions to Psychiatric Illness Following Trauma.

Given that not all children exposed to a traumatic event will go on to develop psychopathologies such as PTSD, ASD or depression, there must be some sort of protective factors in play that promote resilience in these children. Conversely, there must be some factors that make children more prone to the development of psychopathologies following trauma. Researchers have highlighted the need to define any such factors, given that they may hold importance for the accurate prevention and treatment of resultant psychopathologies (Fantuzzo & Lindquist, 1989; Foy, Osato, Houskamp & Newmann, 1992).

A small number of studies have attempted to identify factors which may predispose a child to developing PTSD following trauma. Famularo and colleagues (1996) in a study of traumatised children, found that children with PTSD compared to those without, did not differ significantly on characteristics such as age, race or socio economic status, but

that more males than females met PTSD diagnostic criteria. Conversely, when considering children exposed to domestic violence, girls tend to be at increased risk of psychopathology than boys (Forsstrom-Cohen & Rosenbaum, 1985). The presence of an external locus of control (the belief that the child has little or no control over their life) in children has also been shown to relate to an increased likelihood of psychopathology (Allen & Tarnowski, 1989; Work, Parker & Cowan, 1990). Others have found that increased self blame (Creamer, 1990; Pynoos & Nader, 1990) and increased perception of a threat (Gibbs, 1989; Nader, 1993) are contributing factors to an increased likelihood of PTSD development. Other research by Famularo and Fenton (1994) comparing two groups of parentally abused children with and without PTSD, found factors during the first year of life such as a low birth weight, vomiting, sleep problems, excessive crying and infections, discriminated those who developed PTSD from those who did not. Also, the presence of these factors tended to lead to earlier onset of maltreatment from parents (Famularo & Fenton, 1994). When considering these findings, it should also be considered that this relationship may also be explained by the presence of parental psychopathology (that may have lead to a tendency toward abuse of the child), and that these children may be more prone to developing psychopathologies due to the genetic influence from their parents. That is, the resultant PTSD may be due not just to the trauma, but also in some part, to a genetic predisposition towards developing PTSD. Some research suggests that when exposed to domestic violence, older children fare worse than younger children (Gleser, Green & Winget, 1981; Wolfe, Jaffe, Wilson & Zak, 1985), however some evidence actually suggests the opposite, with younger children faring worse (Hughes & Barad, 1983).

Other research examining factors that predict PTSD occurrence following a childhood trauma has been inconclusive. Kilpatrick and Williams (1998) compared 20 children who had been exposed to domestic violence ($M = 8.1$ years of age, $SD = 1.7$) with 15 matched control children ($M = 8.6$ years of age, $SD = 1.8$). Measures completed by the child or parent included the Child Post-Traumatic Stress Reaction Index (PTSRI; Frederick, 1985), the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973), the General Health Questionnaire (Goldberg & Hillier, 1979), and The Straus Conflict Tactics Scale (Straus, 1979). Factors investigated by the researchers included violence intensity and frequency, age of the child when they first witnessed the domestic violence, time since the last occurrence of domestic violence, mothers

psychological health, perception of threat, age and gender. As would be expected, results indicated that those who had witnessed domestic violence had a significantly higher amount of PTSD diagnoses than the non-witness control group ($\chi^2 = 31.17$, $df = 1$, $p < .001$; these findings were published separately in Kilpatrick, Litt & Williams, 1997). However, findings indicated that none of the factors hypothesised to predict PTSD symptom level were significant contributors to PTSD diagnoses. The sample size used in this study was only quite small and it may be the case that there was inadequate power to observe a significant effect. On the other hand, it should also be considered that perhaps the witnessing of domestic violence is severe enough that most children, regardless of other factors present in their lives, will develop PTSD.

There is a great need for large trials to be conducted utilising not only a larger sample sizes, but also examining groups of children who have undergone exposure to different trauma types. It is quite possible that the type and severity of trauma experienced by the child will impact greatly on the extent of psychopathological outcomes.

Other research has examined factors that may predispose adults to the development of PTSD following an adulthood trauma, such as handedness and presence of the second component of criteria A for PTSD (A2; presence of fear, helplessness or horror). Some of these findings may be applicable to children, although the author is aware of no comparable studies that examined these factors in children.

Prior research has indicated that adults who are mixed-handed (write with their left hand and do other tasks with their right hand or vice-versa), are more likely to be diagnosed with PTSD following being in combat (Chemtob & Taylor, 2003; Spivak, Segal, Mester & Weizman, 1998). The same was also found for adolescents who had been through a hurricane (Chemtob, Taylor, Woo & Coel, 2001). The theory behind these findings is that while the left side of the brain has an increased role in language, the right side has a more significant role in the processing of emotions, and that when someone is mixed-handed, there is a reduced lateralisation of these functions. When hemispheric lateralization is decreased, it could result in the right hemisphere having an increased role in the processing of a threat, while the ability of the left hemisphere to process the context of the situation may be compromised (Chemtob & Hamada, 1984; Chemtob & Taylor, 2003). In addition, Forbes and colleagues (Forbes, et. al., 2006) found that

mixed-handed Vietnam veterans with PTSD, actually had significantly less PTSD symptom improvement during a treatment program, than their 'consistent handed' counterparts. Overall, it seems that adults who are mixed-handed have both an increased tendency to develop PTSD following trauma, as well as a reduced propensity towards recovery following PTSD diagnosis. Hemispheric functions can be localised to the same areas of the brain in childhood and adulthood, however, we cannot conclude that findings regarding handedness can be generalised to child populations until further research has been carried out.

Further research involving adult samples, has examined elements of the trauma experience and their impact on PTSD development. Specifically, researchers have examined the presence of PTSD criterion A2 (the subjective experience of fear, helplessness or horror), and its relation to PTSD symptom development (PTSD diagnostic criteria will be described further in section 3.8.1.). The occurrence of strong fear, helplessness or horror has been significantly associated with increased rates of PTSD (Brewin, Andrews & Rose, 2000) with very few adults going on to develop PTSD in the absence of an A2 response to the traumatic incident (Breslau & Kessler, 2001). In a further investigation of the link between A2 criterion and PTSD development, Creamer, McFarlane and Burgess (2005) examined data from the national Survey of Mental Health and Wellbeing (NSMHWB; conducted by the Australian Bureau of Statistics in 1998), for 6104 adults who had experienced a traumatic event at some time in their life. All participants had completed the Composite International Diagnostic Interview (CIDI: Andrews & Peters, 1998), yielding diagnostic scores for PTSD, generalised anxiety disorder, obsessive compulsive disorder, panic disorder, agoraphobia, social phobia, major depression, dysthymia, bipolar disorder, alcohol abuse, drug abuse and alcohol or drug dependence. Results indicated that 158 adults met diagnostic criteria for PTSD within the prior twelve months, and only four of these did not report fear, helplessness or horror at the time of the traumatic incident. This indicated that of those with PTSD, an overwhelming majority had met the A2 criterion. Additionally, those who reported the occurrence of A2 had a higher prevalence of all other mental health conditions that were measured. Additionally, females were more likely than males to report the presence of both A1 (the trauma) and A2 (the subjective experience of fear, helplessness or horror). This comprehensive study revealed that when an adult experiences fear, helplessness or horror during a traumatic incident, they

are at an increased risk of developing not only PTSD, but a myriad of other psychiatric disorders. This effect appears to be stronger for women than men. These findings help to identify those most at risk for developing psychopathologies, and could assist in the early identification of those who may require psychological assistance. Again, these findings cannot be generalised to children without a comprehensive study of a similar nature to that of Creamer, McFarlane and Burgess (2005). The link between the experience outlined by the A2 criterion and the likelihood of children developing PTSD is a fascinating one that requires urgent research.

Finally, studies have examined predisposing factors to the development of depression following childhood trauma. Factors such as lower socioeconomic status, maternal psychiatric illness and chronic neglect, are associated with a higher incidence of childhood depression following a traumatic incident (Harkness & Lumley, 2008). As was previously stated, maternal psychiatric illness may have a genetic component that is passed on to the child, making the child more vulnerable to developing PTSD in the case of a traumatic incident. There are potentially a great deal many factors that can moderate the relationship between childhood trauma exposure and resultant psychopathologies, and identification of these factors will be of great importance in the early identification of at risk children and possibly even the prevention of poor psychological outcomes.

3.6. Child Reactions to Trauma

Children can react to trauma in unusual and varied ways. Often children either choose not to speak of their experiences or do not have the language abilities to do so, and younger children have a tendency to behave with more overt aggressive and destructive behaviour (Dyregrov & Yule, 2006; Eth & Pynoos, 1985). They may also draw pictures about the trauma and engage in repetitive, symbolic play. Children also tend to react in a similar way to their parents. Calm parents have children who react in more adaptive ways to trauma, as they have provided a stronger sense of security, and set a better example than parents who tend to panic (Dyregrov & Yule, 2006). Similarly, parents who speak about a traumatic incident tend to have children who feel open to speak about and process the event, whereas if children see their parents get upset at mention of

the event, they quickly learn not to mention it (Dyregrov & Yule, 2006). This highlights the importance of taking both parent and child accounts of both the traumatic incident and the ensuing symptoms when working in a clinical or research setting.

As children grow older, reactions to trauma logically progress towards those of an adult as the propensity to understand and discuss the event and its consequences becomes more developed. It is extremely important for good communication to be present between children and their parents to both reduce the risks of developing psychological illness (Rushena, Prior, Sanson, & Smart, 2005), and aid in symptom treatment following trauma. As Salmon and Bryant (2002) suggested, talking with adults can assist children to: recall the traumatic event, interpret the experience, correct misunderstandings or misconception of what actually happened, regulate and manage emotions and facilitate adequate coping strategies. This communication could be vital in the prevention or treatment of trauma related pathologies such as PTSD and depression.

3.7. Anxiety.

The term ‘anxiety’ refers to a complex state that involves emotional, cognitive, somatic and behavioural dimensions (Seligman, Walker, & Rosenhan, 2001). For example, a child suffering from anxiety may experience intense worry and fear, maladaptive or incorrect thoughts regarding the trigger responsible for the anxiety, increased heart rate, sweating and respiration and may show problem behaviours such as tantrums, aggression, and distractibility to name a few. Anxiety problems are one of the most common types of psychological disturbance during childhood and adolescence (Anderson, 1994, Klein & Pine, 2002), and such disturbances can be responsible for poor adjustment and functioning that might continue into adulthood if untreated (Gregory et. al., 2007).

Specific childhood anxiety disorders can take the form of panic disorder, a specific phobia, Posttraumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), generalised anxiety disorder, social anxiety disorder, separation anxiety disorder and obsessive compulsive disorder. A comprehensive review of all anxiety disorders is outside the scope of this thesis; rather, this thesis focuses more on general levels of

anxiety in children of marital dissolution, as well as symptoms of PTSD and ASD. Please refer to “Children’s Anxiety” (Appleton, 2008) for a complete and comprehensive review. In childhood trauma research, diagnoses of specific anxiety disorders are often not made, but rather measures of overall anxiety levels are taken as a matter of interest and to assess how anxiety might factor into other diagnoses of PTSD and depressive symptoms.

Anxiety is commonly reported in conjunction with depression (Clarizio, 1994), and as one would expect, ratings of anxiety are high in those meeting diagnostic criteria for PTSD (Cohen & Mannarino, 2008). Naturally, people experience more anxiety during periods of great change in their lives. It is therefore understandable that children who have witnessed high level conflict between their parents over a period of months or even years, followed by a conflictual parental separation and the ensuing changes to the family dynamic and home life, might report higher levels of anxiety (Hetherington, 2003). In fact, most studies which have examined traumatised children and have utilised some measure of overall anxiety, have found high levels of anxiety (King et. al., 2000; Cohen, Deblinger, Mannarino & Steer, 2004; Cohen, Mannarino & Knudsen, 2004; Cohen, Mannarino & Knudsen, 2005; Deblinger, Mannarino, Cohen & Steer, 2006; Smith et. al., 2007).

The following section will outline the characteristics of PTSD and ASD.

3.7.1. Post Traumatic Stress Disorder.

Symptoms and Diagnostic Criteria for PTSD

The DSM- IV-TR specifies that the following symptoms must be present in order to diagnose child PTSD and they must have been present for at least one month (the following is a summary of information obtained from the DSM- IV-TR, pages 467 - 468).

- A. Exposure to a traumatic event involving death or the threat of death or serious injury to ones-self or another person (criteria A1), along with a response of

extreme fear, helplessness, disorganised and/or agitated behaviour (criteria A2). There are no strict rules as to what can and cannot be classified as a traumatic event. Events that mature adults may perceive as being mildly traumatic, such as the death of a parent, might be hugely traumatic for a child. Whether or not an event can be classified as ‘traumatic’ is essentially entirely open to the subjects own perception of the event and the impact it has on their view of themselves and the world around them.

- B. Re-experiencing of the traumatic incident involving one of either reoccurring and distressing recollections of the event, physiological activation in response to reminders of the event, psychological distress when reminded of the event, reoccurring nightmares, or acting or feeling as though the event were happening again/re-enacting aspects of the event. Children with PTSD will often experience intrusive and highly distressing memories associated with the traumatic incident, such as remembering blood, gun-shot noises, smells, or the look on other peoples’ faces for example. Often children who experience such strong ‘flashbacks’ will not verbalise them but rather will engage in re-enactment of the event through play. For example, children who have been through a natural disaster such as an earthquake will often play games involving an earthquake. Nightmares are also common, often involving the reliving of the event or sometimes generalised upsetting features. Reminders of the event may also trigger extreme physiological arousal in the form of increased heart rate, increased breathing, and sweating and increased muscle tension. These signs are often the easiest for parents or caregivers to pick up on.
- C. Persistent avoidance or numbing of responsiveness. Three or more symptoms from this category must be present for a diagnosis of PTSD to be made. These include: Feeling disengaged or not close to others, being unable to recall aspects of the event, reduced interest in activities, inability to experience certain emotions, feelings that future plans or hopes will not eventuate, avoiding thoughts or feelings to do with the trauma or avoiding places, activities etc that stimulate memories of the trauma.

- D. At least two indicators of heightened arousal, including: sleep problems, irritability and/or outbursts of anger, concentration problems, hyper vigilance and inflated startle response.
- E. Symptoms must have persisted for more than one month.
- F. There must also be the presence of clinically significant distress or impairment in functioning.

PTSD manifests quite differently in children in comparison to adults, largely due to the fact that children tend to show fewer emotional numbing and avoidance problems (Dyregrov & Yule, 2006). Again, capacity to express symptoms using language may be responsible for a lack of reporting of these symptoms. Clinicians therefore need to be able to identify repetitive play that may represent re-enactment of the trauma. Such play may indicate that the child is maintaining a cognitive focus on the trauma. For these reasons, a therapist should discuss the child's behaviour with a parent, who we could assume would be sensitive to any recent behavioural changes in their child.

It has been suggested that children do not have the cognitive capacity to experience the same complex symptoms as adults suffering from PTSD, that is, perhaps these symptoms are simply not present in children (Dyregrov & Yule, 2006). In terms of diagnosis, it should also be noted that boys have a tendency to display more outward behavioural symptoms than girls (Dyregrov & Yule, 2006).

Life-time Prevalence of PTSD

Reported data on the life-time prevalence of PTSD differs vastly depending on country and sample type. For example, Giaconia and colleagues (1995) reported a PTSD life-time prevalence of 6% in a community sample of older adolescents in the USA. Kessler and colleagues (1994), using data collected from a United States community sample of older adolescents, found a life time prevalence of 10%, whereas in a sample of eighth grade Danish students, life-time prevalence of PTSD was reported as 9% (Elklit, 2002). These numbers are remarkably high, suggesting that perhaps as many as 1 in 10 adolescents meet diagnostic criteria for PTSD. Rates of PTSD in adult Australian

samples have been consistently found to be lower than in some other parts of the world. For example, in an Australian study using a large sample of the general population (not specifically examining children), DSM - IV PTSD criteria was met in 1.5% of those sampled, and Composite International Diagnostic Interview (ICD-10) PTSD criteria was met in 3.6% of the sample (Rosenman, 2002). In another study, using data obtained from the Australian National Survey of Mental Health and Well-Being, 1.33% of surveyed adults reported a 12 month prevalence of PTSD (Creamer, Burgess, & McFarlane, 2001). Why adolescents and children appear to have a higher incidence of PTSD is unclear and requires further investigation. It may be that children and adolescents are more vulnerable to PTSD due to their developmental stage. Adults may have a more highly developed capacity to cope with trauma than do children.

These findings indicate that firstly, rates of PTSD appear to be somewhat lower in Australian samples, and secondly, that different assessment measures can yield quite different results- something worth taking into consideration when interpreting prevalence statistics. It should also be considered that people of different regions within a country may be exposed to varying levels of trauma, that is, people living within a poverty stricken region with a high crime rate, may be more likely to witness violent crime than people living in affluent suburbs. Hence the need to interpret statistics with caution, given that samples are often taken from a region in close proximity to where research is carried out, rather than a randomised, country-wide sample.

Prevalence of PTSD following trauma.

Rates of PTSD reported following a traumatic incidence vary greatly due to the use of different methodology and assessment techniques, different trauma types, country of origin as well as the length of time passed since the traumatic incident. It seems more likely for PTSD to manifest following a particularly gruesome trauma (Pynoos, et. al., 1993). La Greca and Prinstein (2002) estimated that 30 - 50% of children exposed to natural disasters display PTSD symptoms, while 5 - 10% meet full diagnostic criteria. A very high number of PTSD diagnoses were made following the sinking of the cruise ship, Jupiter, with 51% of adolescent survivors meeting criteria for PTSD (Yule et. al., 2000). Broberg and colleagues (2005) found that 25% of 275 adolescent survivors of a

fire met full PTSD criteria even 18 months after the incident. A meta-analysis including 2697 traumatised children, who had experienced an array of different traumas, found that 36% met PTSD criteria and that this rate did not differ significantly with age (Fletcher, 1996). In Australian samples, PTSD was present in 18% of Ash Wednesday bush fire victims (McFarlane & Papay, 1992) and 18.3% of Newcastle earthquake victims (Carr, Lewin, Webster & Kenardy, 1989), although in both studies the samples involved adults rather than children. These high rates of PTSD following trauma highlight the need for psychological treatment to be made available following a disaster.

3.7.2. Acute Stress Disorder

Symptoms and Diagnostic Criteria for ASD

The following criteria for ASD are taken from the DSM – IV - TR (American Psychiatric Association, 2000; pages 471 – 472). A diagnosis of ASD requires the occurrence of a traumatic event (as does PTSD) however, symptoms must occur within one month of the trauma. If symptoms persist past this time then a diagnosis of PTSD may be made.

- A. Exposure to a traumatic event (this criterion is the same as Criteria A for PTSD. Please see section 3.8.1 for a complete description of what events constitute trauma).

- B. Three or more of the following dissociative symptoms, experienced either during or following the traumatic event outlined in criteria A:
 - 1. Feeling numb or lacking appropriate emotional responsiveness
 - 2. Less awareness of surroundings
 - 3. Derealisation
 - 4. Depersonalisation
 - 5. Inability to recall parts of the traumatic event

- C. Reexperiencing of the traumatic event via flashbacks, dreams or feeling distressed when reminded of the event

- D. Avoidance of anything that provokes reminders of the event

- E. Anxiety or increased arousal / hypervigilance
- F. Significant distress or reduction in daily functioning
- G. Symptoms that last for at least 2 days and a maximum of 4 weeks and occur within 4 weeks of the traumatic event
- H. The symptoms cannot be better attributed to substance use, a medical condition, an exacerbation of an existing disorder and is not better attributed to Brief Psychotic Disorder.

Prevalence of ASD in children following trauma.

Research data on the prevalence of ASD in children following a traumatic incident is fairly scarce, given that the criteria for ASD were only first described in the DSM – IV - TR in 2000 (American Psychiatric Association, 2000). Prior to the recognition of ASD in the DSM – IV - TR, research tended to examine what was previously referred to as ‘acute PTSD reactions,’ that is, PTSD symptoms that occur within one month of the trauma. These studies were essentially measuring what would eventually become the ASD criteria. Several studies examined acute PTSD in samples of children exposed to traffic accidents and sniper attacks, with rates of acute PTSD occurring in around 57% to 77% of children (Di Gallo, Barton & Parry-Jones, 1997; Milgram, Toubiana, Klingman, Raviv & Goldstein, 1988; Pynoos, et. al., 1987). More recently, a handful of studies have examined the prevalence of ASD criteria in children who have experienced hospitalisation due to injury (Daviss et. al., 2000), or burns (Robert, Blakeney, Villarreal, Rosenberg & Meyer, 1999), with 7% and 10% of children meeting ASD criteria respectively. Others have found much higher rates of ASD, with 75% of children with gun-shot wounds (Hamrin, Jonker & Scahill, 2004) and 56% of earthquake victims (Liu, et. al., 2010) meeting criteria. Conversely, some studies have found only very low levels of ASD, with only 1.6% of children involved in car crashes meeting ASD criteria (Winston, Baxt, Kassam-Adams, Elliot & Kallan, 2005). Rates of ASD are likely to vary widely depending on the severity of the trauma and the support

systems in place around the exposed children. There may also be differences in the rates of ASD amongst children of varying ages. There is a severe lack of research on the prevalence of ASD and the factors that impact on its development.

3.8. Depression.

Depressive disorders such as major depressive episodes and dysthymia, quite often occur in response to a traumatic incident and in combination with PTSD or ASD symptoms (Nader, 2007). Children may not meet full diagnostic criteria, but might still show many symptoms of depressive mood that can be debilitating. DSM - IV - TR diagnostic criteria for major depressive episode and dysthymia are summarised below (American Psychiatric Association, 2000; page 356).

To meet criteria for a **major depressive episode**, the child must present with the following symptoms (DSM - IV – TR; American Psychiatric Association, 2000).

- A. At least five of the following nine symptoms, with one from either symptom 1 or 2. These must have been occurring during the same two week period and be a substantial change from usual functioning.
 1. Depressed mood almost constantly and every single day, for children this might present as being an irritable mood.
 2. Vastly reduced interest and pleasure in most activities, nearly every day.
 3. Significant weight changes, either loss or gain of more than a 5% change, or specific to children, the failure to meet expected weight gains.
 4. Sleep problems occurring almost every day.
 5. Psychomotor agitation or retardation nearly every day.
 6. Lacking energy nearly every day.

7. Feeling excessively worthless or guilty nearly every day.
 8. Reduced capacity to concentrate and think; reduced ability to make decisions.
 9. Thoughts of death, suicidal ideation or suicide attempt.
- B. The symptoms cannot meet criteria for a mixed episode.
- C. The symptoms must cause a significant amount of distress and/or impairment to functioning.
- D. The symptoms must not be due to the physiological effects of a substance.
- E. The symptoms must not be better accounted for by the death of someone close and the associated bereavement.

To meet criteria for **dysthymia**, the child must present with the following symptoms (summary obtained from DSM - IV – TR; American Psychiatric Association, 2000; pages 380 - 381)

- A. A depressed mood for most of the day, on most days for duration of at least one year. In children this might be observed as an irritable mood.
- B. Presence of at least two of the following while depressed:
 1. Appetite changes such as lessened appetite or overeating.
 2. Insomnia or hypersomnia
 3. Less energy or excessive fatigue
 4. Lessened self esteem
 5. Concentration problems, poor ability to make decisions
 6. Feelings of hopelessness

- C. During this minimum one year period, the child must not have been without the symptoms for more than 2 months at a time.
- D. No major depressive episode has occurred during the first year of the disorder. Also, if a major depressive episode previously occurred at some point there must have been complete remission before the onset of dysthymia.
- E. There must have been no past occurrence of a manic episode, a mixed episode or a hypomanic episode and the child must not have ever met criteria for cyclothymic disorder.
- F. The reported problems must not occur entirely during the presence of a psychotic disorder.
- G. The symptoms must not be due to the physiological effects of any drug or medical condition.
- H. The symptoms must cause severe distress and/or impairment of functioning.

Levels of depressive symptoms are best taken directly from the child (where possible), as it has been reported that parents tend to report higher levels of depressive symptoms than their children (Clarizio, 1994).

3.9. Summary.

In conclusion, the occurrence of childhood trauma is relatively common (Costello, et. al., 2002), with the most common types of trauma reported by children being experiencing an injury or accident, witnessing the death or injury of another person, or hearing the news of an unexpected death or accident (Giaconia, et. al., 1995). Evidence suggests that conflictual parental separation may be classed as a form of trauma for a child, given that in a child's world, the sudden loss of a sense of security, safety, trust and a sense of abandonment is very distressing (Weiss, 2001). In addition, PTSD symptoms have been observed in children from high conflict marital separation and divorce (Graham-

Bermann, et. al., 2008), suggesting that PTSD may actually result from this form of trauma. Several factors may predispose children to the development of PTSD following a traumatic incident, including having an external locus of control (Allen & Tarnowski, 1989; Work, Parker & Cowan, 1990), increased perception of threat during the trauma (Gibbs, 1989; Nader, 1993), being of mixed handedness (Chemtob & Taylor, 2003; Chemtob, Taylor, Woo & Coel, 2001; Forbes, et. al., 2006; Spivak, Segal, Mester & Weizman, 1998) and the experience of intense fear, helplessness, or horror during the trauma (Breslau & Kessler, 2001; Brewin, Andrews & Rose, 2000; Creamer, McFarlane & Burgess, 2005). Criteria for psychiatric illness that may result from the experience of trauma (PTSD, ASD and depression) have been described, with additional information provided on how these criteria may apply to children.

Chapter 4: Child adjustment to parental separation and divorce.

4.1. Introduction

The propensity for a child to adjust effectively following conflictual parental separation and divorce is influenced by many factors. Acknowledgement of these factors is paramount when considering intervention design. Chapter four will first consider the varying factors that impact on child adjustment. The cognitive behavioural explanation of child adjustment following divorce, as suggested by Grych and Fincham (1990), will then be described before a review of child adaptive coping strategies is provided. This Chapter will highlight to the reader the importance of the inclusion of certain effective coping strategies in interventions designed to improve child adjustment following a conflictual parental separation or divorce.

4.2. Factors impacting on a child's ability to adjust to parental separation or divorce

Several factors are known to impact on a child's ability to adjust following a conflictual parental separation or divorce. The most important and influential of these factors is conflict. Specifically, children adjust better when parents have a tendency to resolve the conflict. Children who see their parents resolve an issue following verbal conflict, may actually benefit from such an experience, as they learn appropriate problem solving behaviours (Bandura, 1973; Cummings et. al., 1989; Cummings & Davies, 1994). Children also adjust better when the parents are optimistic about the outcomes of the conflict (Cummings & Davies, 2002; Cummings & Wilson, 1999). Conflict of lower intensity and frequency is less harmful to children (Cummings & Davies, 1994; Cummings & Davies 2002; Jourilles, et. al., 1991) however; covert conflict (involving unspoken strain or resentment) is still harmful (Buehler, et. al., 1998; Bolger & Patterson, 2001).

Research has indicated that there are six dimensions of parental conflict that relate to child adjustment. These dimensions are each outlined briefly below.

- 1) **Frequency:** recurrent exposure to parental conflict has been shown to lead to a greater occurrence of adjustment issues in children (Johnston et. al., 1987).
- 2) **Content:** When the topic of conflict is centred on the child, feelings of guilt and shame are more likely to arise (Adamson & Thompsom, 1998).
- 3) **Implication of the child:** If the child feels that they are directly involved in the conflict or are feeling pressure to take sides in the conflict, feelings of depression, anxiety and aggression may arise (Buchanan et. al., 1991).
- 4) **Intensity:** Increased intensity in the form of anger and aggression between parents has been shown to be related to increased behavioural problems in children (Johnston et. al., 1987).
- 5) **Parents Behaviour:** Children display maladaptive behaviours when they have had such behaviour modelled to them by their parents- aggressive parents will often have children with aggression problems (Katz & Gottman, 1997).
- 6) **Resolution:** Parents who resolve conflicts set a positive example for their children, whereas parents who do not resolve conflict promote tension in the household which can lead to further conflict. This is related to increased anger and distress in children (Cummings et. al., 1989; Cummings & Davies, 1994).

The negative effects of conflict on child adjustment have been shown to be reduced when the child has a positive, high quality relationship with at least one parent (Buchanan & Heiges, 2001). Research has also shown that children show more resilience throughout divorce when provided with protective and positive action from parents (Pedro-Carroll, 2005). One of the most important factors promoting resilience is the presence of a positive parental relationship that involves good communication, warmth and responsiveness to the child's emotional needs and consistent discipline (O'Connor, 2003; Hetherington & Stanley-Hagan, 1999; Rushena, Prior, Sanson, & Smart, 2005).

Changes in the quality of parenting during marital break-down are thought to be a major contributor to sudden onset of worsening child behaviour, due to reductions in the consistency of discipline and reductions in the parent's availability to the children

(Wallerstein & Kelly, 1980). During the huge emotional and physical upheaval of a marital breakdown, parents may be understandably preoccupied with their own issues and may temporarily have less time to focus on the emotional well-being of their children. If a parent is also experiencing depression, this will add to a child's difficulty in adjusting to the marital dissolution (Buehler, et. al., 1994). When conflict is not resolved, increased tension in the household can wear on the integrity of parent/child relationships and also alter the consistency of discipline (Fincham, Grych & Osborne, 1994; Krishnakumar & Beuhler, 2000; Wallerstein & Kelly, 1980). Ongoing conflict can reduce the quality of the affective response of a parent to their child, and negative parenting behaviours have been shown to result in poor child adjustment in terms of an increased tendency to withdraw socially, and poorer social and self awareness (Kerig, 2001).

Children who have a close and communicative bond with their parent/s tend to show better adjustment (Emery, 1982). Children benefit when their parents provide an environment with reduced stress, including having consistency in rules, discipline and parental expectations of the child (Buchanan, Maccoby & Dornbusch, 1996). Importantly, when parents provide their child with praise and do not make demeaning comments about the other parent, research has shown that children can be spared entirely from negative post-divorce outcomes such as poor academic achievement and emotional regulation issues (Katz & Gottman, 1997).

Hetherington (2003), in a review of past findings, emphasised that several studies indicated that a close relationship with at least one family member played a crucial role in children's healthy adjustment. In saying this, it is important to note that this relationship must be supportive and communicative, and the parent must not rely heavily on the child for their own support. A pathological alliance can form quickly between an upset parent and their child, with the aim being to turn the child against the other parent (Kelly & Johnston, 2001). This is often the case when conflict over custody arrangements for example, carries on long past the divorce (Emery & Coiro, 1997).

The behaviour of fathers following divorce can impact strongly on child adjustment. Fathers who have a close emotional bond with their child, an authoritative parenting style and who meet child support payments on time, will assist their child/children in

having better well-being and better school performance (Amato & Gilbreth, 1999). Unfortunately, when divorce has been highly conflictual, fathering behaviours are more likely to involve negative and intrusive behaviours with the children as well as withdrawal from their fathering role, and these fathers are more likely to be depressed (Doherty, 1998; Pleck, 1997; Vandewater & Landsford, 1998). These factors may serve to reduce the child's ability to adjust effectively. As pointed out by McIntosh (2003), the point at which the benefit of father contact outweighs the pitfalls of increased conflict remains blurry to say the least. Rather, there is no formula for what works best, hence the need of the legal system to take the above factors in to account when considering what is best for the child when making decisions regarding child custody and visitation arrangements.

It is also worth consideration that high quality sibling relationships have been found to aid child adjustment following conflictual parental separation and divorce (Masten & Coatsworth, 1998). Such support can aid in reducing the negative impact of conflict on the child's sense of self-worth and levels of self esteem (Caya & Liem, 1998).

In a study measuring resilience in families following divorce, it was found that more resilient families had three factors in common: a higher level of commitment to the family, a higher level of social support available to them, and a stronger tendency towards defining stressful situations as being a challenge to the family (Greeff, Vansteenwegen, & DeMot, 2006). Social support from outside the family is also important in avoiding negative psychological outcomes (Barnes, 1999; Rodgers & Rose, 2002), as are the presence of adaptive and positive coping strategies by the child (Sandler, Tein, Mehta, Wolchik, & Ayers, 2000).

In order to obtain the best outcomes for the child following a conflictual parental separation or divorce, the above factors should be taken in to account when devising any form of intervention for this group of vulnerable children. The above factors tell us that an intervention would benefit from implementing strategies designed to reduce child exposure to interparental conflict and increase the quality of the parent/child and sibling relationships. Any intervention should also put emphasis on maintaining consistent discipline and realistic parental expectations of the child, as well as encourage the seeking of additional social support by families. Such strategies may be

achieved by working with not just the child, but with the parent also, and an increase in perceived social support may be achieved by utilising group therapy. Prior research utilising Cognitive Behaviour Therapy (CBT) has supported the inclusion of both child and one or both parents in the therapeutic process (Cohen & Mannarino, 1998a; Deblinger, Lippmann, & Steer, 1996; King et. al., 2000). Involvement of even one parent allows the therapist to provide information to the parent on what the child may go through during conflict, how the parent can best avoid further conflict with their ex-partner, how to maintain consistent discipline and how the parent can best support their child. This way, the child is not only being treated for the psychological distress, but possible causes of this distress will be ameliorated during therapy.

A cognitive behavioural approach to explaining child outcomes following parental conflict will be analysed further in the following section. Specific elements of CBT therapy that may be appropriate for children showing negative outcomes following a conflictual parental separation or divorce will be discussed further in Chapter five.

4.3. A Cognitive Behavioural Explanation of Children's Reactions to Parental Conflict.

In 1990, Grych and Fincham attempted to explain the cognitive processes behind children's reactions to parental conflict, by combining findings from relevant literature. While supporting the six previously discussed dimensions of parental conflict (section 4.2.), their cognitive behavioural framework describes three important mechanisms behind child adjustment, namely, the importance of modelling, marital conflict as a stressor, and the importance of parent-child relationships. This theory will play an important role in informing intervention development for children from conflictual parental separation and divorce.

Based on Bandura's groundbreaking work (1973), Grych and Fincham (1990) suggest that one of the most obvious sources of child maladjustment is that behaviours are learnt from the conflicting parents, who are modelling these undesirable behaviours. That is, when parents address problems by becoming loud, aggressive and hostile, the children will have a tendency to behave in the same way when under the same circumstances, as this is the primary example they have of how to deal with a problem. Children may

learn that aggression and hostility is an appropriate way to handle a problem (Grych and Fincham, 1990). Evidence has shown that children even as young as two find parental conflict to be distressing (Cummings, et. al., 1981). When placed in situations of stress, children can show increased occurrence of behavioural problems (Cummings, et. al. 1989) and have a tendency to principally implement well learned coping strategies that may be immature and less adaptive (Spielberger, 1979). In addition, children exposed to early trauma- particularly abuse- have a tendency to develop attention biases towards fearful and/or angry faces, and are also more likely to misinterpret neutral faces as being sad or angry (Pollack, Cicchetti, Klorman, & Brumaghim, 1997; Pollack et al., 2001; Leist & Dadds, 2009). These tendencies are thought to relate to aggression and conduct problems in children, given that these children are interpreting neutral stimuli as threatening or hostile (Dadds et, al., 2006; Dodge, Price, Bachorowski, & Newman, 1990; Dodge, Pettit, Bates, & Valente, 1995). That is, in daily life, the child interprets the world around them in a more negative light and therefore responds in a defensive or aggressive manner.

As previously mentioned, the integrity of parent-child relationships also plays an important role in how children respond and adjust to marital conflict. High level marital conflict can deteriorate the quality of these relationships, leaving a child feeling vulnerable (Peterson & Zill, 1986).

The following explanation of the cognitive behavioural model of explaining children's adjustment to marital conflict is based on the work of Grych and Fincham (1990) and is still relevant today (Refer to Figure 3.)

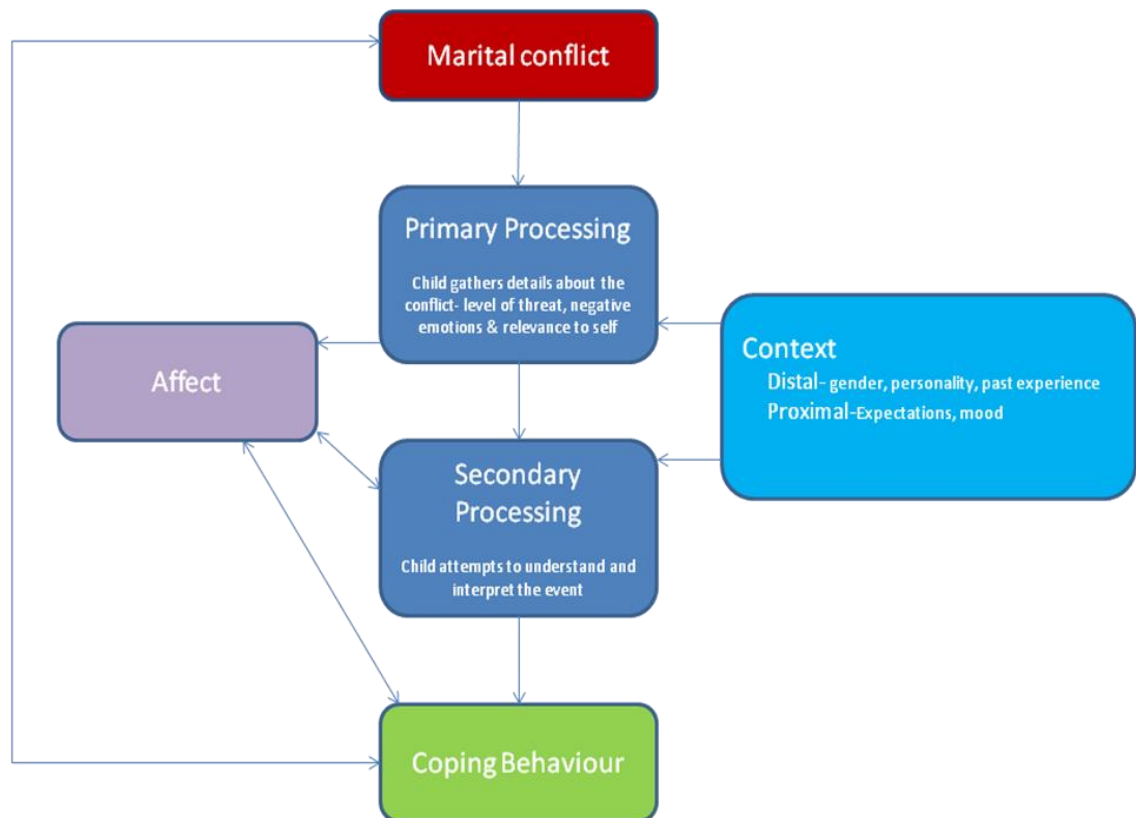


Figure 3. A cognitive-contextual framework for understanding children's responses to marital conflict (Grych and Fincham, 1990).

The cognitive behavioural model shown above, explains the influence of both distal and proximal contexts on a child's interpretation of events surrounding conflict. It is this interpretation of events that will determine adjustment (or maladjustment). Distal factors are more fixed and can include gender, personality, past experience with conflict and perceptions of the family construct. Proximal factors include expectations the child has about what will happen during the conflict and the child's current mood. It is suggested that both distal and proximal factors influence primary and secondary cognitive processing. Primary processing is a basic level of cognition that involves the child gathering details from the conflict regarding negative emotion, threat and relevance to ones self. Secondary processing is a more complex level of cognition where the child attempts to understand and interpret the events. Coping behaviours result from a combination of primary and secondary processing, plus the influence of the child's affective state. Whether the resulting coping behaviour is adaptive or maladaptive will rely on the specific distal and proximal factors that have influenced the child.

There are several types of coping strategies a child might use when dealing with a conflictual parental separation or divorce. Active, problem focused coping strategies involve the child cognitively reframing the situation in a more positive light. This might involve a re-examination of the thinking surrounding an event or the conflict. Active styles of coping in children of divorce have been shown to result in better psychological outcomes (Armistead, et. al., 1990; Sandler, Tein & West, 1994). Examples of active coping that could be encouraged during therapy include encouraging the child to think of alternative ways of interpreting the events surrounding the conflict- that is, identifying maladaptive cognitions and replacing these with more adaptive styles of thinking. This type of coping strategy forms the crux of ‘cognitive therapy’ – an approach that will be described in further detail in section 5.2.1.

In the aftermath of divorce, children may seek additional social support- a coping strategy that has been shown to aid in positive adjustment (Lepore, Silver, Wortman & Wayment, 1996; Pennebaker, 1989; Silver, Boon & Stones, 1983). Sharing details about traumatic or upsetting events with other children or adults can reduce ruminations about the divorce or conflict and also help the child cognitively process events. If a child is being treated for psychological symptoms in the aftermath of a conflictual parental separation or divorce, the support the child gains from the therapist may be pivotal in aiding child adjustment. Perhaps children of conflictual parental separation and divorce would also benefit from a group therapy approach, so that they can share their experiences amongst other children who have been through similar events. Child group therapy has been utilised in several treatment programs from children of varying forms of trauma exposure, with positive results (Deblinger, Stauffer & Steer, 2001; Pedro-Carroll & Cowen, 1985).

Children may also try to avoid thoughts, memories and reminders of the events surrounding the conflictual parental separation or divorce, as a means of coping. Some researchers have suggested that this may in some cases be beneficial for the child, as the child can process their experience slowly while avoiding heightened distress (Horowitz, 1982; Tait & Silver, 1989).

Other coping strategies children can use will need to be taught to them. This often occurs in a therapeutic situation. Stress Inoculation Training (SIT) has been used

extensively in treatment programs for children who have heightened distress or anxiety, and findings have supported its effectiveness (Berliner & Saunders, 1996; Cohen & Mannarino, 1993; Saigh, 1998). SIT involves teaching the child strategies to help them relax, given that children who are having difficulty coping following exposure to a traumatic event such as conflictual parental separation and divorce, are known to have increased levels of anxiety (Weir, 2006). This can involve a combination of muscle relaxation and breathing techniques that the child learns to use when feeling overwhelmed. This technique will be discussed further in Chapter five.

4.4. Summary.

In summary, child adjustment to conflictual parental separation and divorce is enhanced by several factors including: reduction in interparental conflict (Cummings & Davies, 1994; Cummings & Davies 2002; Jourilles, et. al., 1991), maintenance of close and supportive relationships between the child and their parent (Buchanan & Heiges, 2001) and emotional responsiveness and consistent discipline from the parents (O'Connor, 2003; Pedro-Carroll, 2005; Hetherington & Stanley-Hagan, 1999; Rushena, Prior, Sanson, & Smart, 2005). Grych and Fincham's (1990) cognitive behavioural explanation for child adjustment following parental divorce supports these factors and has helped to inform intervention design by highlighting the need to include therapeutic components that address these factors. Additionally, the use of active coping strategies by the child, along with increased social support and the teaching of relaxation strategies, have all been shown to be beneficial to child adjustment, and as such, are important factors for consideration in intervention design. Cognitive Behavioural Therapy (CBT) is a form of therapy that has been used to treat psychological symptoms in children following varied forms of trauma and it utilises many of these components in its approach to treatment. Chapter five will provide a comprehensive description of CBT methods as well as evidence of the effectiveness of this approach in helping children through trauma.

Chapter 5: Interventions for children following a conflictual parental separation or divorce

5.1. Introduction.

Very little scientific literature exists that describes studies of interventions for children from conflictual parental separation or divorce. There is some limited advice available for paediatric nurses (Melnik & Alpert-Gillis, 1997) to direct these health care professionals in the detection of children who are having difficulty coping with divorce, however, there is no standard form of evidence based intervention to which health care providers can refer families.

One program designed to assist children and parents following parental separation or divorce, is the COPE program (Creating Opportunities for Parent Empowerment; Melnyk & Alpert-Gillis, 1996). A small randomised controlled trial involving 21 mothers and their children (average age of 4 years), was conducted in order to examine the effectiveness of the COPE program compared to a control group. Importantly, children and their mothers were not referred in to the program for specific behavioural or emotional concerns, or for PTSD symptoms, but rather, the program was designed to be of benefit to any family undergoing separation or divorce, no matter the level of functioning or prior conflict. The COPE intervention program involved providing parents with information about the normal reactions of children to divorce, with suggestions on how the parent could help their child to adjust, as well as a workbook component that encouraged parents to complete activities designed to aid implementation of the information provided. In order to test the effectiveness of the program, mothers in both the COPE intervention program and the control group, completed measures examining anxiety (State Trait Anxiety Inventory; Spielberger, Gorsuch & Lushene, 1970), mood (BiPolar profile of Mood States; Lorr & McNair, 1982), child adjustment (The Behavioral Assessment System for Children; Reynolds & Kamphaus, 1992) and parenting quality (Nursing Child Assessment Teaching Scale; Barnard, 1978 and the Home observation for Measurement of the Environment; Caldwell & Bradley, 1984). Results indicated that the intervention program successfully

reduced mother's levels of anxiety and negative mood and resulted in an increase in the quality of their parenting. In addition, children of the intervention program had significantly fewer externalising behaviour problems than their control group counterparts. These findings indicated that families may benefit from receiving information and guidance following parental separation and divorce. It must be noted however, that such findings may not necessarily be applicable to children from highly conflictual parental separation or divorce that are showing symptoms of PTSD, depression or anxiety for example. Also, this program is not available outside of the area where the trial was conducted (New York).

To the authors knowledge (based on extensive searches of scientific databases) there has been no evaluation completed of an intervention program specifically for children showing PTSD symptoms, anxiety or depression following a conflictual parental separation, however, there has been research evaluating the effectiveness of interventions for these symptoms, that have resulted from other forms of trauma exposure. This literature has predominantly focused on the treatment of PTSD symptoms in children.

Treatment for childhood PTSD is crucial. In a 33 year follow up of children who survived the Aberfan landslide, 29% of those traced still met criteria for PTSD (Morgan, Scourfield, Williams, Jasper & Lewis, 2003). This highlighted the potential long term negative impact of untreated childhood PTSD, not to mention the other comorbid illnesses that are frequently present in those meeting PTSD criteria.

Several treatment methods are available to children following trauma, each with varying degrees of support in the scientific and clinical communities. The most commonly utilised approaches to treatment come under the heading of 'Cognitive Behavioural Therapies' (CBT). These were born from a combination of Pavlov's early classical conditioning experiments (Pavlov, 1927) in behaviour modification and later from Beck's development of the 'cognitive restructuring' paradigm (1975). Unfortunately, there is a shortage of research that utilises a randomised controlled design in examination of the effectiveness of child psychological treatments for fear reactions. Even so, CBT has undergone more controlled clinical trials than any other form of child

therapy. Given the support to date for this approach, CBT methods form the entire focus of this thesis.

The body of CBT research examining adult trauma victims, far outweighs the small amount of research examining child CBT efficacy. Given the differences in PTSD symptom presentation between adults and children that were previously discussed, it would be reckless to treat children using the same techniques as adults, without first testing their efficacy.

Chapter five will first describe components of CBT; followed by a comprehensive critique of the research to date that has examined the effectiveness of such interventions in the treatment of PTSD symptoms following child trauma exposure. Programs designed to prevent negative outcomes in children following parental separation or divorce will then be discussed. Lastly, the appropriate use of child assessment measures for children exposed to trauma will be discussed as well as some of the issues surrounding adequate assessment of this vulnerable group.

5.2. Cognitive Behavioural Therapies.

Cognitive Behavioural Therapy (CBT) covers a variety of styles of therapy that are all based on the idea that underlying maladaptive thoughts surrounding a trauma can be changed to more appropriate and accurate thoughts that can aid in the amelioration of symptoms (Rachman, 1997). CBT is also based on the premise that behaviours are learnt and can therefore be unlearned. It assumes for example, that learnt fear responses following trauma can be unlearned, and a recovery to a normal state can be achieved (Rachman, 1997). More adaptive and useful behaviours are encouraged. A CBT therapist works with the patient to identify the link between thoughts, feelings and behaviours, and might arrange a self-implemented reward system for desirable behaviours. Styles of CBT include Cognitive Therapy, Stress Inoculation Training (SIT), Prolonged Exposure and Systematic Desensitisation. These cognitive and behavioural styles of treatment are often combined during a course of therapy, but for ease of explanation, will be discussed as separate techniques throughout this chapter.

5.2.1. Cognitive Therapy

The idea of ‘cognitive therapy’ was born in the 1960’s as psychiatrist Aaron T. Beck began to lose faith in the psychodynamic approaches popular at the time. Beck began to believe that it was the way in which people thought about and perceived themselves and the world around them that determined good outcomes from therapy (Beck, 1975). The idea behind cognitive therapy is that negative, maladaptive and incorrect thinking, or negative schemas, are what often underlie psychopathologies such as depression, and that if these harmful thoughts could be changed then the emotional state of the person would also improve (Beck, 1975). Cognitive therapy draws a direct link between how what we think, directly influences what we feel- that is, if we can change bad thoughts into more helpful thoughts, a burden is taken off the person, and they feel much better. An example of a bad schema might be: ‘I am awful at exams.’ A more constructive and helpful way to think would be ‘I will try my best on this exam.’ The second option is a much more positive, realistic and helpful way to think, that would facilitate a much more positive emotional state. When this style of therapy is delivered to children, the term ‘stinking thinking’ can be used to describe negative schemas in a way more easily understood by children. As described earlier, this type of re-examination of thinking, when utilised by children of conflictual divorce and separation, results in more positive psychological outcomes (Armistead, et. al., 1990; Sandler, Tein & West, 1994).

At its inception, cognitive therapy went against popular behavioural approaches. Over time, both cognitive and behavioural approaches were recognised as being valuable and so they are often combined into one encompassing approach- Cognitive Behavioural Therapy.

5.2.2. Stress Inoculation Training

Stress Inoculation Training (SIT) was initially designed to bridge the gap between cognitive based and behavioural based therapies, by incorporating elements of both

styles of treatment (Meichenbaum, 1977). SIT is designed to reduce physiological and emotional stress (Meichenbaum, 1996). In the case of treating PTSD and other anxiety disorders such as phobias, it aims to reduce the physiological stress reaction and induce a more positive psychological state that makes it easier for the person to cope. Examples of SIT such as calm breathing techniques and progressive muscle relaxation are both commonly taught to children who have been through trauma. Once children master these simple techniques, they can utilise them in any situation that induces anxiety or fear.

One of the first steps in SIT is to identify the stressor, and to collaborate with the patient on possible strategies that may serve to reduce stress when confronted with the stressor (Meichenbaum, 1996). Collaboration with the patient, rather than direct instruction from the therapist, allows the patient to feel they have some control over and input into problem solving strategies implemented in therapy. Following this, a form of relaxation training may be introduced. This technique will then be rehearsed with the therapist before the patient applies the technique in their day to day life (Meichenbaum, 1986).

As first described by Cannon (1929), when sufficiently stressed, the human body will prepare for the ‘fight-or-flight’ response, preparing to deal with a stressor. Typically, breathing rate increases, the heart beats faster to pump oxygen to the larger muscles groups, we sweat to cool our bodies down, muscle tension increases and digestion slows down as blood is redirected towards the limbs (Refer to Everly & Sobelman, 1987 for a review). This reaction in itself creates an unpleasant sensation throughout the body which only increases our anxiety. SIT training aims to return the body to a relaxed state by ‘over-riding’ the automatic ‘fight - or - flight’ arousal response. That is, SIT when successfully implemented, can reverse the physiological reactivity of the nervous system to a stressor (Meichenbaum, 1996). SIT training has been shown to effectively reduce distress and anxiety in children (Berliner & Saunders, 1996; Cohen & Mannarino, 1993; Saigh, 1998), and might be particularly beneficial to children of conflictual parental separation and divorce.

5.2.3. Exposure Techniques

A fear reaction provoked by reminders of a traumatic incident can be intense and extremely distressing. Prolonged exposure is a technique first developed by Edna Foa that utilises both cognitive and behavioural approaches (Foa & Kozak, 1986). Prolonged exposure is always preceded by SIT training so that the patient has the necessary skills to cope with the anxiety provoking memory of the trauma. This technique usually involves the patient being in proximity to a stimulus that triggers fear. The idea is that the physiological fear response will habituate with time, and result in the person feeling calmer and less stressed when near the feared stimulus (Foa & Kozak, 1986). In one of the first controlled trials examining people experiencing a phobia of rats (Foa, Blau, Prout & Latimer, 1977), participants experienced the lessening of fear responses with even mild prolonged exposure to rats. Further research over time has highlighted the usefulness of prolonged exposure in reducing fear reactions to a stimulus (Foa & Goldstein, 1979; Foa, Skeketee, Turner, & Fischer, 1980; Steketee, Grayson, & Foa, 1985; van Minnen & Foa, 2006). This form of exposure is useful when there is a specific tangible object that the patient is fearful of.

In vivo exposure is a form of exposure that involves ameliorating fear responses to a situation by actual real life exposure (Foa, Steketee & Grayson, 1985b). This may involve revisiting the scene of a trauma, perhaps with the therapist, and going over the event in small stages or steps, while habituating the stress response with SIT training.

Other forms of exposure are more appropriate when dealing with children who are showing anxiety and fear following a traumatic incident. Imaginal exposure (sometimes called ‘_imaginal flooding’) is a technique which involves the therapist prompting the child to imagine specific upsetting parts of their traumatic experience (Cohen et. al., 2000). The child rates their distress each time they imagine the specific scene, and typically, overtime habituation of the distress is observed.

Gradual exposure is a slightly different technique, whereby the therapist asks the child to describe a less upsetting aspect of their trauma, and then prompts the child to describe and expand their description over several weeks (Deblinger & Heflin, 1996). Usually description of the traumatic event begins in a rather simple, non-confrontational form of discussion and moves towards the patient giving a comprehensive account in the first person of the event (Cohen et. al., 2000). Ratings of fear are also taken and these

typically ameliorate over several weeks. This rather gentle form of exposure therapy is often favoured when treating children, and has an evidence base to support its use (Saigh, 1989; Saigh et. al., 1996). It is also a useful form of exposure therapy given that it can be implemented within the clinic setting without any need to leave the place of treatment.

All forms of exposure therapy are based on the idea that the patient's fear response will eventually habituate, allowing the patient to be able to 'relive' the event (or face the feared stimulus) while experiencing minimal or no fear. This is particularly useful in the treatment of PTSD, since as previously described, many PTSD sufferers experience the reliving of the traumatic event via flashbacks, nightmares or cognitive fixation on the event (refer back to section 3.8.1).

5.2.4. Systematic Desensitisation

Systematic Desensitisation was born from the school of Behavioural Therapy and was developed by Joseph Wolpe (1969). It is very commonly used as a treatment for phobias. If for instance, a patient had a phobia of travelling in cars following involvement in a serious car accident, the therapist could set up a hierarchy of goals to achieve, that would lead up to the ultimate goal of having the patient drive a car again. Very small steps are taken and the patient does not proceed to the next stage until they can cope with one stage with minimal anxiety (Wolpe, Brady, & Serber, 1973). In this example, the therapist might begin with asking the patient to spend time looking at a car, for perhaps a few minutes at a time. SIT training would have already been taught to the patient and they would practice these skills in order to keep the bodily stress reaction as minimal as possible. After the patient was able to achieve this goal they may spend time washing the car or sitting in the car while stationary, and gradually build up to going for a short ride as a passenger and eventually to driving the car themselves. This process can take many weeks, months or even years. If the patient can repeat each stage until they no longer feel anxious and then step up to the next level on the hierarchy, they can very effectively ameliorate their phobia (Wolpe, Brady, & Serber, 1973).

While systematic desensitisation may initially seem very similar to in vivo exposure, they are actually quite different. While in vivo exposure aims to allow a patient to experience minimal or no distress when confronted with reminders of a trauma, systematic desensitisation aims to ameliorate a specific phobic fear (of an object, place or situation) that has become entrenched since a trauma, hence allowing for more normal functioning.

Overall, CBT covers a variety of techniques that all essentially aim to do two things. Firstly, to identify maladaptive thinking and to change these thoughts into more accurate and helpful thoughts, and secondly, to change or ‘unlearn’ problem behaviours, instead using more useful or helpful behaviours. The research discussed in the following section provides strong support for the use of CBT techniques for the treatment of traumatised children.

5.3. The evidence base behind CBT approaches to treating childhood trauma symptoms.

Prior to 1996, there existed no published literature demonstrating the efficacy of child trauma-focused CBT using a randomised controlled study design. Since then, several important studies have emerged, each supporting the use of CBT in treating traumatised children. Several of these studies included follow-up assessments one or two years post treatment. This section will describe the methodology and samples used in these studies, and critically review key findings.

In 1996, two separate research teams concurrently carried out the first randomised clinical controlled trials of Trauma Focused-CBT (TF-CBT). Firstly, the research of Cohen and colleagues will be discussed followed by the research of Deblinger and colleagues.

Cohen and Mannarino (1996) randomly allocated 67 children who had been sexually abused (aged 2- 7 years) and their parents to either a CBT condition or a Non-directive Supportive Therapy (NST) condition. The CBT model developed for use in this study

was termed the 'CBT-SAP.' The child treatment for the CBT-SAP condition involved components such as safety and assertiveness education, thought-stopping, positive imagery and problem solving. For the parents, the CBT-SAP condition addressed issues such as 'providing emotional support to the child,' managing problem behaviours in the child and managing their own fear and anxiety symptoms. The NST condition was utilised as it was considered a more ethical option than a waitlist control, given that recently sexually abused children with PTSD symptoms were involved. NST involves a therapist making supportive statements and offering encouragement, however, there is no direct specific advice given to the recipient. The Child Behavior Checklist-Parent Version (CBCL; Achenbach & Edelbrock, 1983) and Child Sexual Behavior Inventory (CSBI; Friedrich et. al., 1992) were administered to the parents at intake and again after 12 weekly treatment sessions. Weekly behavioural reports were also obtained from parents. The children completed the Preschool Symptom Self-Report (PRESS; Martini et. al., 1990), a measure consisting of 25 sets of two illustrations, of which one picture represents a problematic behaviour. The child picks which one best represents their own behaviour. Audiotapes of each treatment session were rated by an independent scorer who was blind to which condition was being examined. All sessions scored above 90% compliance with treatment guidelines, and treatment modality was correctly identified by the rater 100% of the time. Results indicated that while the CBT group showed significant improvement in scores on the CSBI, weekly behaviour ratings and the four main CBCL scales, the NST group only showed symptomatic improvement on the weekly behaviour ratings. The CBT-SAP group did not show improvement on the CBCL social competency scale. There were no significant differences in PRESS scores between conditions, and no significant change in scores over time for either condition, although initial scores were very low. This may illustrate the tendency for children to give a desirable response in the presence of an adult, highlighting the importance of therapists remaining impartial to children's responses. CSBI and three of the four CBCL scores were initially mostly within the borderline or clinical ranges. Following CBT-SAP treatment these scores had all fallen into the non-clinical range, whereas for the NST condition, two of the CBCL scores were still in the borderline clinical range. It was concluded that the CBT-SAP condition was an effective treatment for preschool children displaying PTSD symptoms following sexual abuse.

Forty-three of the children from this study and their parents were contacted for follow up assessments at 6 and 12 months after treatment (Cohen & Mannarino, 1998a). Parents completed the same measures as they had previously, as well as the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996), the Family Adaptability and Cohesion Evaluation Scales-III (FACES III: Olson et. al., 1985), the Parent Emotional Reaction Questionnaire (PERQ; Cohen & Mannarino, 1996b), the Parental Support Questionnaire (PSQ; Mannarino & Cohen, 1996), and the Maternal Social Support Index (MSSI; Pascoe et.al., 1988). The children also completed developmental measures including the Battelle Developmental Inventory (BDI; Newborg, et. al., 1984) and the Peabody Picture Vocabulary Test (PPVT; Dunn, 1965). Treatment group was found to be the best predictor of outcome, with parental support and the PERQ scores also being strong predictors. The authors concluded that parental involvement in therapy is highly desirable to facilitate an optimal outcome, and that there was evidence to suggest that CBT is an effective treatment for preschool children showing PTSD symptoms following sexual abuse.

In a similar study, Cohen and Mannarino (1998b) compared the efficacy of a Sexual Abuse Specific Cognitive Behavioural Therapy (SAS - CBT) program to Non-directive Supportive Therapy (NST), in children aged 7 to 14 years who had been sexually abused. The children and their parents completed 12 treatment sessions with a therapist, and in accordance with the 1996 research, were similarly monitored for adherence to the treatment manuals. The SAS - CBT group was found to experience greater improvement in scores on the Children's Depression Inventory and the Social Competence sub scale of the CBCL, than the NST group, indicating that the CBT approach was considered an appropriate treatment for sexually abused children aged 7 to 14 years.

Deblinger, Lippmann and Steer (1996), carried out a study concurrently to Cohen and Mannarino (1996) that also examined the efficacy of a TF-CBT program for sexually abused children. Deblinger and colleagues aimed to examine the influence of parental involvement on the abused child's recovery. TF-CBT was given to either the child alone, the parent alone or both the child and non-offending parent. A control group was offered standard community care such as receiving information on abuse and associated symptoms that may occur. Participants in any of the three treatment conditions attended

12 weekly therapy sessions. The child-only and parent-only sessions ran for approximately 45 minutes each and the combined parent and child sessions ran for around 80-90 minutes. The child treatment involved common CBT methods such as providing information about abuse and coping strategies, teaching safety skills and using techniques such as gradual exposure and modelling. The parent treatment involved providing advice and information on how the parent could best provide support and respond therapeutically to their child. The parents were taught strategies in reducing fear and anxiety in their child, by using modelling and gradual exposure techniques. Measures completed by the children included the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E; Orvaschel, Puig-Antich, Chambers, Tabrizi, & Johnson, 1982), the State/Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973), the Child Depression Inventory (CDI; Kovacs, 1985), as well as a comprehensive background interview. The parents completed the CBCL on behalf of their child, the Parenting Practices Questionnaire (PPQ; Strayhorn & Weidman, 1988), as well as a background interview.

Results indicated that children who received treatment (regardless of parental condition) showed significantly greater improvement in PTSD symptoms than children who did not receive treatment. Children whose parents received treatment (regardless of whether the child themselves also received treatment), indicated significantly better improvement in symptoms of depression and in behavioural problems that were reported by parents. These findings highlighted the importance of including non-offending parents in the therapeutic process given those children whose parents were involved in therapy, experienced greater therapeutic gains. In addition, this research highlighted the usefulness of obtaining parent report of child behavioural problems.

In a follow-up of these families (Deblinger, Steer, & Lippmann, 1999), participants completed the same assessment measures previously used, at 3 months, 6 months, 1 year and 2 years post treatment. It was found that the improvements originally observed between intake and post treatment assessment, were maintained over the following two year period. This indicated that CBT based treatment does not only provide immediate symptom improvement but that these improvements may indicate a permanent and lasting change. This particular study examined symptoms over a much longer time

period following treatment than other studies- which typically examine follow up data at assessments completed between three months to one year post treatment.

King and colleagues (2000) carried out research in Melbourne, Australia, examining the efficacy of CBT, with the aim of determining whether family involvement would further enhance therapeutic gains. A total of thirty-six sexually abused children aged 5 to 17 years were assigned to either CBT with their non-offending mother (family CBT; $n = 9$), CBT without their parent (child-only CBT; $n = 9$) or a waitlist control group (WLC; $n = 10$). Children assigned to either of the two treatment conditions received 20 weekly sessions, each of 50 minutes duration. CBT methods included cognitive therapy, relaxation training, behaviour rehearsal, self-talk methods, and graded exposure. There was no treatment given to the parents whose children took part in the child-only CBT condition. In the family CBT condition, non-offending mothers received weekly sessions for 50 minutes each, over 20 weeks. The parent treatment content focused on teaching the mothers better communication skills to use with their abused child, and teaching skills to facilitate discussion of the abuse with their child. The parents were also taught how to manage their child's behaviour effectively, using a positive approach when the child was implementing adaptive coping strategies. Parents also completed homework with their child between treatment sessions. Children and parents completed assessments at intake into the program, following completion of the program and then at a 12 week follow up. Measures completed by the children included the Fear Thermometer for Sexually Abused Children (Kleinknecht and Bernstein, 1988), the Coping Questionnaire for Sexually Abused Children (this was developed by the researchers) the Revised Children's Manifest Anxiety Scale (Reynolds and Richmond, 1978) and the Children's Depression Inventory (Kovacs, 1981). Parents completed the Child Behavior Checklist (CBCL; Achenbach, 1991). Each clinician also used the Global Assessment Functioning (GAF; American Psychiatric Association, 1987) scale in order to determine overall levels of psychological, social and school functioning. Children who completed treatment were found to have significantly better scores on all PTSD symptoms and fear thermometer ratings than the WLC group. There was no significant difference on Revised Children's Manifest Anxiety Scale (RCMAS) scores between treatment and wait list control groups at post treatment, but a significant difference emerged at the follow up assessment, indicating that the treated children showed a greater improvement in anxiety symptoms. Surprisingly, only one significant

difference between child-only CBT and family CBT conditions was found. Children from the family CBT condition showed significantly less fear (as measured by the fear thermometer) than child-only CBT participants, and this was only observed in the follow up assessments. Parent ratings on the CBCL revealed greater improvements in PTSD scores in the treated children than the waitlist controls, but there was no significant difference between the child-only CBT and the family CBT conditions. Following treatment and at follow up, significantly less children met criteria for PTSD than the waitlist control group. The authors concluded that either CBT condition was beneficial in treating PTSD symptoms, but that family involvement in therapy may not be as important as previously perceived. Participant numbers in each group were only small, and the authors concluded that further research utilising larger samples was required.

Deblinger, Stauffer and Steer (2001) carried out research comparing the efficacy of a CBT group programme for sexually abused children (aged 2-8 years) and their non-offending mothers, to a NST control group condition. All participants, regardless of condition, attended 11 weekly group sessions, of 1 hour 45 minutes each although the CBT condition participants completed an extra 15 minutes of combined parents and child group activities. The CBT parent group addressed three main areas: teaching parents skills to cope with their own emotions effectively, teaching parents how to facilitate communication with their child in regards to the abuse, and teaching parents how to manage their child's behavioural problems. The parent group content was based on work described by Deblinger and Heflin (1996). The researchers developed a structured NST parent group manual based on their consultation with community support group leaders. Discussions in the NST parent group were led by the parents, with the group leader providing active listening, reflection and encouragement. The child CBT group and the child NST groups covered similar content to each other, with the main difference being in the delivery of the information to the children. Both groups covered three main areas: improving communication about feelings, identifying appropriate and inappropriate touching, and learning abuse response skills. This content was presented to the CBT group children in an interactive way, using workbooks, whereas the NST group had the information presented to them in a much more instructive presentation format. In either group, children were not requested to speak

specifically about their own experiences. While some common CBT components were utilised, this particular research did not utilise cognitive processing and exposure techniques that other research has used. Assessments were undertaken at intake into the programme, after programme completion and then at a 12 week follow up. Measures completed by the mothers included the Miller Behavior Style Scale (Miller, 1990), the SCL-90-R Posttraumatic Symptom Scale (SLR-90-R; Derogatis, 1983), the Impact of Events Scale (IES; Arata, Saunders, & Kilpatrick, 1991), the Parent Emotional Reaction Questionnaire (PERQ; Mannarino & Cohen, 1996), the Parent Practices Questionnaire (PPQ; Strayhorn & Weidman, 1988), the Social Support Questionnaire (SSQ; Zich & Temoshok, 1987) and a Therapy Satisfaction Questionnaire (TSQ) that was developed by the researchers. The parents also completed the following instruments on behalf of their children: the PTSD scale component of the Kiddie Schedule for Affective Disorders and Schizophrenia for School Age Children-Epidemiologic version (K-SADS-E; Orvaschel, Puig-Antich, Chambers, Tabrizi, & Johnson, 1982), the Child Behavior Checklist (CBCL; Achenbach, 1991), and the Child Sexual Behavior Inventory (CSBI-3; Friedrich, et. al., 1992). The children completed the What If Situations Test (WIST; Sarno & Wurtele, 1997), designed to determine a child's ability to identify and respond to a hypothetically abusive situation. To summarise, the children from the CBT group had greater improvements in safety skills than the children from the NST group. Mothers from the CBT group had reductions in intrusive thoughts and fewer negative parental emotional reactions than their NST counterparts. Both the child CBT and mother CBT groups were superior at improving symptoms than the NST groups, however, it was concluded that either form of assistance, whether therapeutic or supportive, was beneficial in improving symptoms.

In 2004, the first multi-site, large scale study of TF - CBT was carried out, which included a large sample size ($N = 229$) of sexually abused children aged 8 to 14 years, from city, suburban and rural areas at two sites in the USA (Cohen, Deblinger, Mannarino, & Steer, 2004). The aim was to cover the shortcomings of sample size and limitations on participant demographics that previous research had encountered. All children involved displayed significant PTSD symptoms, with 89% meeting full diagnostic criteria. Children and their non-offending parent were randomly assigned to either TF - CBT or Child - Centered Therapy (CCT). CCT is a treatment model based on what would commonly be offered in community settings in places such as rape crisis

centres. It involves assisting the parent and child in developing a trusting relationship. Parents and children direct their own sessions and can decide when or whether they discuss the child's abuse. CCT is similar to NDST, in that they both allow the patient to have some input into the direction of the sessions and the therapist offers support and encouragement rather than treatment per se. The TF - CBT condition involved the utilisation of gradual exposure techniques- where the children identified and detailed distressing memories of the abuse, thought and feeling recognition, cognitive therapy, education about child sexual abuse and the teaching to the parent of child behaviour management skills. The children and parents completed assessments first at intake into the program and then following treatment. Child measures included: the K-SADS-PL (Kaufman, et. al., 1996), a semi structured interview administered to both the child and parent to determine the presence of any DSM – IV - TR psychiatric disorders, the Children's Depression Inventory (CDI; Kovacs, 1985), the State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973), and the Children's Attributions and Perceptions Scale (CAPS; Mannarino et. al., 1994). The parents completed the Child Behaviour Checklist (CBCL; Achenbach, 1991), the Child Sexual Behavior Inventory (CSBI; Friedrich et al., 1992), the Beck Depression Inventory (BDI; Beck et al., 1996), the Parent's Emotional Reaction Questionnaire (PERQ; Mannarino & Cohen, 1996), the Parental Support Questionnaire (PSQ; Mannarino & Cohen, 1996), and the Parenting Practices Questionnaire (PPQ; Strayhorn & Weidman, 1998), which had been slightly changed in order to be appropriate for the sample used (Stauffer & Deblinger, 1996). Both the parents and children of each condition showed significant improvement over time on all measures except the PSQ. Although both groups showed significant improvement, the TF-CBT participants showed significantly greater improvement in symptoms than the CCT group, on measures including the K-SAD-PTSD subscales, CBCL total score, CDI, CAPS, BDI and PERQ. More than twice the number of CCT children in comparison to TF-CBT children, continued to meet PTSD criteria following treatment. It was concluded that TF-CBT provided superior treatment for sexually abused children. Given that more than 90% of the participating children also reported some other form of trauma, the authors suggest that TF-CBT may be suitable for treating PTSD that eventuates from a range of trauma types. It may be that PTSD eventuating from a range of differing forms of trauma, has more similarities than previously believed. More research is required to confirm this supposition.

In a follow up to this multi - site study (Deblinger, Mannarino, Cohen & Steer, 2006), assessments of the children and their non-offending parent were again carried out at 6 months and 12 months post treatment. Findings revealed that both children and parents who had taken part in the TF-CBT treatment, continued to show fewer PTSD symptoms than those who took part in CCT. In addition, ratings of abuse specific parental distress were lower in the TF-CBT parents than the CCT parents.

Given the potentially adverse long-term effects of sexual abuse on the developing child, it is of particular importance in research that children have a follow up assessment to ensure that any therapeutic gains are maintained in the long term. Cohen, Mannarino and Knudsen (2005) assigned 82 adolescents aged 8 to 15 years, and their non-offending parent, to either a TF-CBT treatment or to Non - Directive Supportive Therapy (NDST). The TF-CBT treatment involved the same common CBT treatment techniques described previously (Cohen, Deblinger, Mannarino, & Steer, 2004a). The NDST also followed previously described methods (Cohen, & Mannarino, 1996, 1998b). Results revealed superior symptom improvement for the TF-CBT participants in comparison to NDST participants on measures of depression, anxiety and sexual problems, that were maintained at both 6 month and 12 month follow-up assessments. This provided support for the robustness of TF-CBT in the middle and long term.

The term ‘psychological trauma,’ is an umbrella phrase that covers a plethora of possible traumatic incidents. For example, the experience of a child who battles terminal cancer, witnesses a shooting, or witnesses interparental conflict, would be rather different to the experience of a child who is routinely sexually abused. Given that research examining CBT methods has been predominantly focused on child victims of sexual assault, it would be unacceptable to generalise the findings to other trauma populations. There is some research that has examined CBT as a treatment for other types of trauma. Some of these key studies will be discussed further below.

Cohen, Mannarino and Knudsen (2004b) examined the efficacy of a CBT program designed to treat symptoms of traumatic grief. When children experience PTSD symptoms following the death of someone close, the normal process of grieving can be obstructed. Treatment was based largely on the methods utilised in their past research, with additional elements that addressed traumatic grief symptoms. Treatment took the

form of eight 60 minute trauma - focused therapy sessions, followed by another eight sessions that were focused on grief symptoms. Parents also received individual therapy, with two joint parent - child sessions. Twenty-two children and their parents completed treatment. This was unfortunately not a controlled trial as there was no control group utilised. Intake and post-treatment assessment measures completed by the children included: the Expanded Grief Inventory (EGI; Layne, et. al., 2001b), the Children's PTSD Symptom Scale (CPSS; Foa, et. al., 2001), the Mood and Feelings Questionnaire (MFQ; Angold, Costello & Messer, 1996), and the Screen for Children's Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997). Parents reported on their child's symptoms by completing the UCLA PTSD Index for DSM-IV Parent Report Version (UCLA Index; Pynoos et al., 1998), and the Child Behavior Checklist (CBCL; Achenbach, 1991). The parents also completed the PTSD Diagnostic Scale (PDS; Foa, 2001) in order to report on their own symptoms of PTSD. Following sessions 4, 8, 12, and 16 of therapy, the children repeated the EGI and CPSS measures, as these time points were considered to be important milestones in the therapeutic process. The children were found to show significant improvements in symptoms of CTG, PTSD, depression, and anxiety and also in behavioural problems. Interestingly, significant improvements in PTSD symptoms were only observed during the sessions that were focused specifically on the treatment of trauma symptoms, whereas, traumatic grief symptoms showed improvement over both the trauma-focused and grief-focused treatment components. Parents own symptoms of depression and PTSD also showed significant improvement. This study was the first to indicate that CBT could be useful in treating not just sexual abuse victims, but also those experiencing PTSD following the traumatic death of someone close.

Cohen, Mannarino and Staron (2006b) completed further research in order to examine whether the treatment of children experiencing traumatic grief symptoms, could be made more efficient, yet still as effective. Thirty-nine children aged 6 - 17 years old with CTG symptoms and their parents, underwent the same treatment utilised in the 2004 research, however they received it over a condensed 12 sessions rather than 16. The treatment still took the form of an initial module of trauma focused treatment, followed by a CTG focused module. Results were in keeping with past findings, with children showing significant improvements in PTSD symptoms during the trauma focused module, while CTG symptom improvement was significant throughout both the

trauma focused and CTG focused modules. This indicated that delivery of CBT over 12 weeks can yield significant improvements in symptomatology. Given the debilitating effects of CTG and PTSD symptoms on a child, utilising a treatment approach that is fast, efficient, and efficacious is of utmost importance.

Smith and colleagues (2007) examined a sample of 24 adolescents aged 8 to 18 who had experienced a single incident trauma such as a car accident or an act of violence. All children met criteria for a PTSD diagnosis. Participants were either placed in a 10 week CBT program or were allocated to a wait list control (WLC) group. The CBT program included components such as imaginal exposure, cognitive restructuring, and revisiting the scene of the trauma, but unlike other CBT treatments mentioned above, did not include components such as relaxation training or any other anxiety management techniques. All of the participants (including parents) completed the Anxiety Disorders Interview Schedule (ADIS-C/P; Silverman & Albano, 1996) in order to screen for PTSD symptoms and diagnoses as well as any other disorders. The Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA; Nader et. al., 1994) was also administered. The children completed the Child PTSD Symptom Scale (CPSS; Foa et. al., 2001), the Children's Revised Impact of Events Scale (C-RIES; Perrin et. al., 2005), the Depression Self Rating Scale (DSRS; Birlerson, 1981), the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) and the Children's Post Traumatic Cognitions Inventory (C-PTCI; Meiser-Stedman, 2009). Overall, findings revealed that CBT participants in comparison to WLC participants, experienced greater improvement in symptoms of PTSD, depression and anxiety. The results were also clinically significant with the CBT group showing a higher rate of recovery from PTSD (92%) than the WLC group (42%). These findings provided evidence that CBT approaches could be effective at reducing PTSD symptoms and improving overall functioning in not just sexually abused children, but also in children exposed to single incidences of trauma.

Continuing on with single incident trauma victims, Shooshtary, Panaghi and Moghadam (2008) examined the efficacy of an intensive 3 day CBT program for adolescent earthquake victims, aged 11 to 20. Some 135 victims of the 2004 earthquake in Bam, Iran, completed the 3 day treatment, and were compared to a control group of 33. Participants completed the Impact of Events Scale (IES-R) both before and after

treatment. The CBT program included components such as psychoeducation, relaxation training, self-talk methods, cognitive therapy and imaginal exposure. Testing was carried out 4 months after the earthquake. IES ratings were taken at intake and then 4 weeks later, once treatment was complete. Those who completed the CBT program showed significant improvements in all three PTSD symptom categories in comparison to the WLC participants. This study was important in highlighting the benefits of even a very short CBT program.

More recently, Tucker (2010) described a randomised controlled trial (both conducted and presented by Dr. Judith Cohen at the annual meeting of the Anxiety Disorders Association of America) that aimed to examine the effectiveness of Trauma Focused – Cognitive Behavioural Therapy (TF – CBT) in a sample of children aged 7 to 14 years, who had been witness to domestic violence inflicted upon their mother. Children were randomised to either the TF – CBT group ($n = 43$) or the ‘Child Centred Therapy’ (CCT; described above) group ($n = 32$). Inclusion criteria included that the child must present with at least five PTSD symptoms, with at least one symptom from each PTSD symptom cluster (re-experiencing, avoidance and arousal). Importantly, many of the children were still witnessing on-going conflict between their parents. To account for this, the TF – CBT group had an increased focus on discussing safety for the child and a decreased emphasis on treating the ‘re-experiencing’ symptoms of the trauma exposure, given that these children typically *were* re-experiencing the trauma in their day to day lives. Components of the TF – CBT program included elements such as providing psychoeducation and parenting skills to the parents, teaching the children relaxation skills and methods for coping, the production and processing of a trauma narrative, as well as the teaching of skills to increase safety. The CCT approach involved active listening from the therapist and encouragement of both the child and mother to implement their own problem solving strategies. Results indicated that the TF – CBT program was significantly better at reducing avoidance, hyper arousal, overall PTSD scores and anxiety, and was significantly better at enhancing cognitive function in the children, than the CCT approach. In terms of clinical PTSD diagnosis, clinically significant improvements were observed in 75% of the TF – CBT group, vs. 44% of the CCT group, a highly significant difference. Firstly, these findings indicate that CBT models of intervention can provide significant benefit to children of high level interparental conflict who are displaying PTSD symptoms, and secondly, that these

benefits may still be apparent even when the source of trauma (the interparental conflict) is ongoing.

Recent research has emerged that examined the efficacy of CBT for abused children (Feather & Ronan, 2006, 2009; Runyon, Deblinger & Schroeder, 2009), as well as American Indian children who had been exposed to violence (Morsette, et. al., 2009). In all cases, a manualised trauma-focused CBT program was implemented, with promising results. However, participant numbers in each study were small and study design did not follow the more robust model of a randomised controlled trial, but rather, each study relied on comparisons between baseline and follow-up data or analysis of case studies.

Overall, past research findings suggest that children who have been sexually abused can be successfully treated using CBT. There is some evidence that traumatic grief, some single incident traumas, natural disaster survivors, those exposed to domestic violence and abused children might also be successfully treated using CBT, although, there is not enough research available to form definitive conclusions on the best treatments for children exposed to these trauma types.

It is extremely important that treatments are not only effective but are also efficient. As will be described further in section 5.5.3, early trauma can have a lasting neurological impact on the brain (Cook, Ciorciari, Varker & Devilly, 2009; (Felitti, et. al., 1998; Mulvihill, 2005), making it of paramount importance that post traumatic stress symptoms and frequently comorbid depression and anxiety symptoms, are treated both in the quickest time frame, and in a form that promotes a permanent return to healthy functioning. There is not only a severe lack of research examining the efficacy of CBT for children from differing trauma backgrounds, but there is also a lack of research examining just how quickly PTSD symptom amelioration can be achieved. Given the past research findings described throughout this chapter, it also appears that there are benefits to having a non-offending parent involved in therapy.

More randomised controlled trials are required that examine the efficacy of CBT in samples of children who have undergone more common forms of trauma. One of the most common forms of trauma children face in today's society is that of conflictual parental separation.

5.4. Programs designed to prevent negative outcomes in children following parental separation or divorce

Several prevention programs implemented in the USA have aimed to prevent poor psychological outcomes following parental separation. Rather than recruiting children based on evidence of existing psychological illness, these programs recruited any child of divorce, with the aim of preventing any psychological illness from eventuating. For example, the ‘_Children’s Support Group’ (Stolberg & Mahler, 1994), was a school-based prevention program, that involved some 103 children who had been through parental divorce. Children were randomly assigned to one of three treatment groups: support; support and skill building; support, skill building, transfer and parent training procedures; or a control group who received no training. In addition, 26 children from non - divorced families acted as ‘_non-stressed’ controls. The skill building component involved the labelling of emotions, relating these emotions to events and using these emotions in sentences directed at others. The skills building component also involved teaching the children how to self-control as well as teaching skills in how to problem solve effectively. The skills transfer component involved a children’s workbook which involved completing home work for future sessions, and encouraged the child to practise newly learnt skills. The skills transfer component also involved a concurrent parent workshop that encouraged parents to be involved with their child’s progress and to help their child learn new skills. The skills building component was found to be responsible for significant reductions in internalising and externalising behaviours. The inclusion of the skills transfer component with skills building, resulted in significant improvements in trait anxiety, but behavioural improvements were not observed until a one-year follow up. All components of this study were cognitive behavioural in nature. The skills building plus support condition resulted in better clinical improvements than any other condition at post-treatment assessments, however, the support only condition yielded better clinical symptom improvement at follow-up than all other conditions. Lastly, by post – treatment follow-up, levels of affective adjustment and behaviours of the treatment groups were comparable to that of the non-stressed control group. Overall, this study found that a school based prevention program in children of divorce was effective at preventing poor psychological outcomes following divorce.

Another program aimed at preventing poor outcomes in children post-divorce, was the ‘_Children of Divorce Intervention Project’ (Pedro-Carroll & Cowen, 1985). This project involved children from the 4th through to 6th grade in primary school, half of which began the program immediately, and half of which had delayed involvement and served as the control group. Topics covered in the 10 session treatment, included: encouraging the children to speak together about divorce, their feelings and what divorce has meant for them; educating the children about why parents divorce and ameliorating feelings of blame; cognitive skills building including positive self statements, finding ways to deal with problems that are within the child’s control and recognising when a problem is within a parents responsibility and not their own; and how to effectively control their anger. The program was found to result in significant improvements on teacher ratings of problem behaviours and competence, and parents also rated their children as being less anxious and better adjusted. A replication of these findings some years later, provided further support for the Children of Divorce Project (Pedro-Carroll, Sutton, & Wyman, 1999).

The prevention program entitled ‘_Parenting Through Change’ (Forgatch & DeGarmo, 1999) has been shown to be beneficial in preventing poor outcomes in boys aged 6 to 10 who have been through a parental separation. This program was administered to mothers over 14 weeks and taught parents how to provide effective positive reinforcement of their children’s behaviour, consistent discipline, as well as problem solving skills, and how to handle conflict and negative feelings (Martinez & Forgatch, 2001). It was found that boys whose mothers took part, indicated significantly lower non-compliance at a 30-month follow-up, compared to boys in a control group. In addition, the mothers demonstrated that at follow-up, they had maintained the positive parenting skills they had learnt throughout the program (Martinez & Forgatch, 2001).

The ‘_New Beginnings Program’ (Wolchik, et. al., 2002), is another prevention program administered to parents following divorce, that has shown promising results. Participants were placed into one of two treatment conditions, namely; mother alone (mother attends 11 treatment sessions) or mother and child (mother completes 11 sessions, as does the child- separately). There was also a control condition that received books on coping with divorce. The mothers group included content aimed at improving mother/child relationships, improving the use of effective discipline, and reducing

interparental conflict. The mother and child group included the same content as the mothers group, however had additional components aimed at reducing negative thinking, improving coping skills and improving child - parent relationships. The first study examining this program involved mothers with children aged 8 to 15. The program was found to improve aggression and behaviour problems in the children, and also improve mother - child relationships. Another study of this program involving families with children aged 9 to 12, revealed the same short term improvements in behaviour, along with a plethora of benefits at a six year follow-up (Wolchik, et. al., 2000). Some of the benefits of the program included fewer externalising problems, fewer mental illness symptoms as well as better academic performance, in comparison to children from the control group. This important study helped to further reveal the benefits that preventative programs may have in reducing poor outcomes in children following separation and/or divorce and in particular, highlighted that initial therapeutic gains may continue to positively impact on children in the longer-term.

While it is preferable to prevent behavioural and emotional problems from occurring in the first place, it should be noted that a great deal many children show resilience to parental separation and divorce (Greeff & Van Der Merwe, 2004; Hetherington, 2003; Kelly & Emery, 2003; McLanahan & Sandefur, 1994; Rushena, Prior, Sanson, & Smart, 2005) and such prevention programs would be of little use to them. A prevention program would be most suited to those children who are at risk of poor outcomes-particularly those who have been through a conflictual parental separation or divorce. A more targeted approach to prevention would reduce costs associated with providing the service and would help ensure that the most needy children have access to the interventions resources. The above studies illustrate that taking steps to improve the consistency of discipline and improve parent – child relationships, can significantly improve outcomes for children of separation and divorce. Such strategies would be worthy of inclusion in treatment protocols for these children.

5.5. The psychological assessment of children following trauma.

Developing assessment measures for children is no easy task, given that reading and writing skills and comprehension of language, varies so greatly for children of different

ages. While some measures are more appropriate for children of a specific age, in research it is often vital for one uniform measure to be administered to a sample of children that vary in age by some years. For these reasons, when assessing a child's reaction to trauma it is important to gain reports from both the child as well as either the caregiver or a teacher, in order to gain the best representation of the traumatic event and any ensuing problems (Jensen et. al., 1999). For example, children may have trouble verbalising or explaining complex symptoms, but often an adult would have picked up on unusual behaviours which provoked them to seek assistance or treatment for that child (Jensen et. al., 1999). Also, adults tend to have a much more accurate knowledge of the length of time since the event than the child, whose sense of time is often distorted (Jensen et. al., 1999). It has been found that children are more accurate at reporting their own emotions and feelings than their parents are at reporting them on their child's behalf (Korol et. al., 1999). Section 5.5 will outline the most important and well validated measures available for assessing children who have been exposed to a traumatic event such as conflictual parental separation or divorce, building a case for their inclusion in both a clinical and research setting.

5.5.1. Assessing PTSD, general child behaviour, depression, anxiety and facial emotion recognition in children following trauma exposure.

When working with children who have been through a trauma, either in a research or a clinical setting, it is important to make an assessment of PTSD symptoms in order to determine the presence and strength of any reaction to the traumatic experience. Several forms of structured and semi structured diagnostic interviews for PTSD exist. The problem with such assessments is that they are difficult to quantify and therefore, reliability and validity data is scarce. It is becoming more common for clinicians to use a multimodal approach that utilises both interview and self report measures. Self report measures are often a preferred choice for researchers as they can provide an easily quantifiable profile of PTSD symptoms in a short amount of time, using fewer resources (Deville, Varker, Cook & Yap, 2008).

An example of a useful self report measure for a child to complete (with the assistance of a therapist who can read out and tick off responses) is the Child PTSD Symptom

Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001). The language is easy for children to understand; it allows for a PTSD diagnosis to be made and includes 17 questions, one from each of the DSM-IV criteria to assess symptoms present in the last month. There are also 7 questions that assess daily functioning. From the 17 items, scores can be calculated to form scores for the three symptom clusters of reexperiencing, avoidance and arousal. The CPSS has shown good reliability and very good convergent and divergent validity (Foa et. al., 2001), and has been used previously to examine the effectiveness of a therapy program for traumatised children (Cohen, Mannarino & Knudsen, 2004b).

It is also important in either a clinical or research setting, that a wide range of child behaviours are measured, given that research has indicated that trauma can impact upon a plethora of child behavioural outcomes (Boris & Zeanah, 1999; El-Sheikh & Harger, 2001; Liberman & Van Horn 1998; Main & Cassidy, 1998; Zeanah, et. al., 1999). Since caregivers are better at reporting externalising behaviours in children rather than emotions and feelings (Jensen, et. al., 1999), the Child Behaviour Checklist (CBCL; Achenbach, 1991) is a popular choice that allows for an extensive array of symptom assessment. It is a frequently used measure that is an almost standard inclusion in research with traumatised children. The CBCL provides clinical scores for the internalising measures of withdrawal, somatic complaints and anxious/depressed symptoms. The externalizing scales provide scores for the two clinical syndromes—delinquent behaviour and aggressive behaviour. This measure is discussed in more detail in chapter 6.3.3.

The Children's Depression Inventory (CDI; Kovacs, 1992) was developed from the Beck Depression Inventory (BDI; Beck, 1967), a measure designed to assess adult depression. The CDI is widely regarded as an excellent tool for assessing children's depressive symptoms and is the most cited and well researched measure available (Finch, Saylor, & Edwards, 1985). It is frequently used in studies examining child outcomes following trauma (Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Lippmann & Steer, 1996) as it can quickly provide insight in to the level of depressive symptoms in children following a trauma. It is easily understood by children (aged 6 to 17 years) and quick to administer, at only 27 items, each of which present three statements, to which the child picks the one that describes them best in the last two

weeks. It has good psychometric properties and while it does not provide a diagnosis, it is a useful start point to determine whether further investigation and assessment is required.

Anxiety is commonly reported in children who have been through trauma, making it important that accurate measures of general anxiety levels are taken by clinicians and researchers alike, as anxiety levels may inform the focus of the intervention for the child. The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) provides subscale scores to indicate levels of physiological anxiety, worry/oversensitivity and social concerns/concentration. It is a commonly utilised tool in child trauma research, with good psychometric properties (Smith et. al., 2007). Even from the subscale titles, one can infer the relationship between anxiety levels and PTSD, ASD and depression. For example, physiological signs of anxiety form part of diagnostic criteria D for PTSD and ASD (as mentioned previously), and concentration problems form part of a diagnosis for depressive disorders. It is therefore important to take a general measure of anxiety symptoms in children who have experienced trauma, as even if they do not meet diagnostic criteria for a specific anxiety disorder, general anxiety symptoms can be debilitating and may be intrinsic to some other underlying disorder.

It is also important for clinicians and researchers to consider the child's own perception of their emotional state, particularly when implementing therapy. Given that children don't always have the language to describe their own feelings, using pictorial forms of assessment can be advantageous. From a very young age, children will use the emotional expressions of adults to regulate their own behaviour, when placed in new situations (Gunnar & Stone, 1984). This is commonly referred to as 'social referencing.' It is thought that this instinct to reference behaviour according to an adult's emotional expression is designed to aid survival, so that the child can avoid dangerous, potentially life-threatening situations. In keeping with this theory, it has been found that infants pay more attention to objects that have received negative adult attention, rather than objects that received positive attention, or no attention at all (Carver & Vaccaro, 2007).

Several studies have examined the neural correlates of infant responses to emotive adult faces. Infants who have been victims of maltreatment (yet not severe enough to have

been placed in foster care), show neural abnormalities when viewing emotive faces, in comparison to non-abused infants (Cicchetti & Curtis, 2005). Similar neural differences have been found in institutionalised Romanian children (Moulson, Fox, Zeanah, & Nelson, 2009) and children with high trait anxiety (Holmes, Kragh Nielsen, & Green, 2008). It is therefore, generally accepted, that neural abnormalities of the facial/emotional recognition regions of the brain exist in maltreated infants. It is unknown what sort of long-term impact on behaviour or psychological well-being, these neural abnormalities may have.

These neural abnormalities may relate to behavioural data which has indicated that abused, neglected, or highly anxious children, have a tendency to be better at recognising angry faces rather than happy faces (Pollack, Cicchetti, Klorman, & Brumaghim, 1997; Pollack et al., 2001), and to rate neutral faces as being either sad or angry (Leist & Dadds, 2009). In addition, Smith and Walden (1998) found that children from a disadvantaged, low income background had a tendency to be better at recognising fearful faces. This was thought to reflect the likelihood that these children experience more stressful living situations, where negative emotional facial expressions may be more prominent. It might be that these children are primed towards these types of expressions, given their past exposure to them (Herba & Phillips, 2004). It has also been found that physically abused children are more likely to identify faces as showing anger, than non-abused children (Pollack & Kistler, 2002). It is not clear whether children from adverse backgrounds are better at identifying negative emotions, or rather are more likely to interpret a face as showing a negative emotion. The subject of emotional identification in traumatised children remains largely unexplored. There is a call for further research in this field, given that there is evidence to suggest that poor emotional recognition of others during childhood is related to poor emotional and social regulation in adulthood (Parker & Asher, 1987) and various child psychopathologies (Cicchetti & Schneider-Rosen, 1984).

Inclusion of a measure such as the Pictured Feelings Instrument (PFI; Shack Stone, 2004) would be highly valuable when working with traumatised children in a therapeutic setting. Not only does such a measure offer a unique insight in to the child's experience of emotions they may not yet have the language to describe, but as described above, perception of faces may also be linked to later child adjustment. The PFI consists

of 26 cards that depict faces showing differing emotions. The child is asked to firstly, identify what they would be feeling if they were the person in the picture, and secondly, to rate how often they feel like the person in the picture. Such a measure has not been utilised in any past research studies examining the effectiveness of an intervention in the treatment of trauma symptoms, however, given the evidence supporting a link between facial emotion recognition and child trauma exposure, there is a strong case for inclusion of this measure in future research.

5.5.2 Psychophysiological considerations when dealing with traumatised children.

It has been suggested that the sensitive state of the neural system during childhood may be in part responsible for psychopathologies present in children after a psychological trauma (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006). The brain undergoes enormous growth and change with the pruning, myelination and organising of neurons continuing to around the age of ten years (Giedd et al., 1999; Paus, et. al., 2001; Pfefferbaum, et. al., 1994; Sowell, Trauner, Gamst, & Jernigan, 2002). When the child brain is in a state of prolonged or severe stress, inappropriate neural networks, perhaps susceptible to mental illness, can develop (Felitti, et. al., 1998; Mulvihill, 2005). Several studies have found unusual levels of certain catecholamines in children following trauma (Yehuda, 1997, 2000) and it has been suggested that this may be in part responsible for altered neural development (De Bellis, 2001; Weber, & Reynolds, 2004).

This author's prior research (Cook, Ciorciari, Varker & Devilly, 2009) indicated that adults reporting a childhood trauma displayed significantly different neural connectivity than adults reporting either adulthood trauma or no past trauma. It was hypothesised by the authors that these changes may be responsible for the increased rates of mental illness experienced by adults who have reported childhood traumas. Perhaps experiencing a trauma at a young age can significantly alter neural development to the degree that the person remains susceptible to mental illness throughout their life (Cook, Ciorciari, Varker & Devilly, 2009). While only a hypothesis at this stage, there is enough preliminary evidence available to suggest that a great deal of research examining the neural correlates of traumatised children is warranted. Unfortunately, this

area falls outside the scope of this thesis. Future research would benefit from the inclusion of psychophysiological measures that examine neural development in traumatised children; given the evidence that early trauma may have a lasting impact (Cook, Ciorciari, Varker & Devilly, 2009).

5.5.3. Comorbidity of Psychiatric Disorders in Traumatized Children

The accurate assessment and identification of psychopathologies following trauma is extremely important to ensure that adequate psychiatric assistance and support can be provided to achieve optimal recovery. Often aspects of one disorder are common in some way to the diagnostic criteria of another disorder. For example, children meeting PTSD criteria often report feeling as though their future plans will not eventuate. This feeling of hopelessness is inherent to a diagnosis of depression. Adequate assessment is required to ensure that the child in this case is not just treated for depression, but also for the fear reactions inherent to a PTSD diagnosis.

Rates of comorbidity following trauma are quite high. In a study examining psychiatric comorbidity in abused children meeting criteria for PTSD, Famularo and colleagues (1996) found that children with PTSD had higher rates of anxiety disorders, brief psychotic disorders, mood disorders, suicidal ideation as well as ADHD. Donnelly and Amaya-Jackson (2002) also reported on the higher incidence of ADHD, conduct disorder and oppositional defiant disorder in children with PTSD. They speculated that these conditions may relate to the hyperarousal aspect of PTSD.

It is therefore extremely important that children presenting with PTSD symptoms are thoroughly assessed for other conditions. Measures such as the RCMAS (Reynolds & Richmond, 1978) and CDI (Kovacs, 1992) are simple and quick ways of determining whether anxiety and/or depression symptoms exist. The CBCL (Achenbach, 1992) is another very comprehensive measure that covers a range of symptoms covered by the DSM – IV - TR, that when completed by the caregiver, can give valuable insight into any behavioural issues.

There are several mechanisms that may explain comorbidity. It might be that one disorder is actually the cause of another disorder, that there is some sort of shared genetic or environmental etiology, there might be predisposing factors to particular disorders or it may be purely coincidental that two disorders are occurring in proximity to each other (Silberstein, 2001). In a clinical setting, it is important to consider the possible reasons for comorbidity and to establish exactly where symptoms are overlapping, and how this might determine the course of treatment.

5.5.4. Issues Surrounding Assessment.

To gain the most reliable and comprehensive description of both the traumatic experience and ensuing distress, it is vital to complete assessments of both the child and a parent or caregiver. It has been reported that children are better at reporting on their internal experiences such as mood and anxiety, whereas parents are better reporters of their children's externalising behaviours for disorders such as conduct disorder, Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (Fallon & Schwab-Stone, 1994; Feldman et. al., 1995).

The social desirability response bias is a phenomenon described as the tendency for a person to want to present themselves in a way that is considered favourable (Crowne & Marlowe, 1960). When assessing children, it must be considered that a child may want to respond in a socially desirable manner- perhaps answering in a way that would down-play the occurrence of violence in the home. Children have a tendency to want to please adults, so it is most important for the assessor to remain impartial and neutral to any given response by the child. Children have been shown to play-down psychological distress (Kazdin & Petti, 1982) as well as deny negative feelings and thoughts (Paulhus & Reid, 1991). More recently, Logan and colleagues (2007) found that children scoring high on a measure of social desirability reported fewer symptoms of anxiety and depression than low scoring counterparts. Children have also been shown to be more susceptible to this response bias than adults (Mwamwenda, 1995). Additionally, in the case of Parental Alienation Syndrome (PAS; described in detail in section 2.3), which is more common when separation or divorce has been conflictual (Weir, 2006), children

have a tendency toward increased condemnation of the non-resident parent. This could potentially extend to the child exaggerating the severity of the conflict in order to present the alienated parent in a particularly bad light. A similar response bias may also be present when the parent reports on the child's symptoms – that is, the parent may be motivated to exaggerate the child's symptoms as a means of displaying the negative impact that the other parent has on the child. A child's view of both their parents, and the impact of the conflict on their own life, is particularly open to influence during parental conflict when there may be pressure to be loyal to one parent (Crossman, Powell, Principe & Ceci, 2001; Lee & Oleson, 2001). The assessment of both the child and the parent for child symptomatology and detail surrounding the conflict is essential given the above mentioned factors. The susceptibility of these children to PAS should be considered during any form of assessment.

5.6. Summary.

To summarise, treatment of trauma symptoms following any form of trauma is essential, given that PTSD can linger for many years (Morgan, Scourfield, Williams, Jasper & Lewis, 2003). One of the most widely used and tested treatments for child fear reactions following trauma is Cognitive Behavioural Therapy. Components of CBT, including cognitive therapy, stress inoculation training, exposure techniques and systematic desensitisation have been shown to effectively treat trauma symptoms following child sexual abuse (Cohen, Deblinger, Mannarino & Steer, 2004; Cohen & Mannarino, 1996, 1998a, 1998b; Cohen, Mannarino & Knudsen, 2005; Deblinger, Lippmann & Steer, 1996; Deblinger, Mannarino, Cohen & Steer, 2006; Deblinger, Stauffer & Steer, 2001; Deblinger, Steer & Lippmann, 1999; King, et. al., 2000), childhood traumatic grief (Cohen, Mannarino & Knudsen, 2004b; Cohen, Mannarino & Staron, 2006b), witnessing of domestic violence (Tucker, 2010), child abuse (Feather & Ronan, 2006, 2009; Runyon, Deblinger & Schroeder, 2009) and varied single incident traumas (Morsette, et. al., 2009; Shooshtary, Panaghi & Moghadam, 2008; Smith, et. al., 2007). No research to date has examined the effectiveness of CBT in the treatment of children with PTSD symptoms following a conflictual parental separation, despite evidence suggesting that this form of trauma may be quite common (Wolcott & Hughes, 1999) and may have negative psychological outcomes for the child (Buchanan, Maccoby, &

Dornbusch, 1991; Davis, Hops, Alpert & Sheeber, 1998; Hetherington, 1991; Grych & Fincham, 1992; Sarrazin & Cyr, 2007). Some research has aimed to prevent negative psychological outcomes in children of parental separation and divorce (Forgatch & DeGarmo, 1999; Pedro-Carroll & Cowen, 1985; Stolberg & Mahler, 1994; Wolchik et. al., 2002) however; these interventions were not targeted for children with serious pre-existing psychological problems. Even so, these prevention programs have demonstrated that child outcomes following divorce can be improved by providing educational materials to the parents on how to maintain consistent discipline and giving the parents skills to improve their relationship with their child. There is a great need for the development and testing of a CBT program designed to treat children who are showing PTSD and other psychological symptoms following a conflictual parental separation, and intervention protocols will be well informed by the research described within this chapter. Careful selection of materials used for assessing these children as well as consideration of the unique biases that may be present in this vulnerable sample, will be required.

Chapter 6: The Efficacy of a Seven-Week Cognitive Behavioural Therapy Program for Children showing Fear Reactions Following a Conflictual Parental Separation.

6.1. Introduction.

In Australian society, the prevalence of divorce is quite high with 47, 963 divorces granted in 2007, equating to some 2.3 divorces per 1000 of the population (ABS, 2008). Almost half (49.3%) of all divorces are between adults who have children under the age of 18 (ABS, 2008), meaning that many children undergo the series of life changes associated with parental separation or divorce. Statistics also indicate that a large portion of Australian children experience the trauma of witnessing inter-parental violence (Trewin, 2005), and the psychological damage inflicted by this can be substantial (Grych & Fincham, 1990). Children who are witness to parental conflict are known to be at increased risk for health, social and economic problems, as well as drug and other substance abuse (McLanahan, 1999). They are also more likely to experience anxiety, aggression, hostility, increased internalising and externalising behaviours, depression and low self esteem (El-Sheikh & Harger, 2001; Kerig, 1999, 2001; Weir, 2006). The negative psychological impact of divorce has been demonstrated by well designed studies (Stadelmann, Perren, Groeben & von Klitzing, 2010; Strohschein, 2005).

When interparental conflict exists, children are at increased risk of not reaching important developmental milestones such as: the development of trust and an understanding of the link between cause and effect, the development of healthy and secure attachment to parents, the ability to self regulate emotion and arousal, the development of beliefs about the self, the ability to create relationships with other children and the ability to function well at school (Crockenberg & Langrock, 2001). Developmental requirements may not be met when there is a high level of stress in the child's life, given that the child's resources tend to be directed towards finding a way to cope with the conflict, rather than the developmental tasks at hand (Wallerstein & Lewis, 1998; Zill, Morrison & Coiro, 1993). Additionally, parental conflict has been shown to last for up to two years following divorce (Moskowitz, 1998) and degree of conflict is

more strongly related to psychological illness in children, than is marital status (El-Sheikh, Harger, & Whitson, 2001). This means that conflict is typically spread over a long time period and it is unlikely to be centred on the time of the formal separation or divorce. Divorce and conflict also has a negative impact on the parents involved. Parents who separate or divorce are more likely to experience anxiety, depression, increased health problems and substance abuse (Hughes & Waite, 2009; Lorenz, Wickrama, Conger & Elder, 2006; Zhang & Hayward, 2006).

Conflictual parental separation and divorce may be distressing enough to be considered a form of trauma for the child (Graham-Bermann, et. al., 2008). When a child's sense of safety and trust in their parents is compromised, and if one parent is suddenly absent, the child may feel abandoned, which can be significantly traumatic for a child (Weiss, 2001). Children who have been through a conflictual parental separation or divorce have been shown to score highly on measures of posttraumatic stress symptoms (Graham-Bermann, et. al., 2008). Also, there are many similarities between the negative psychological outcomes following a conflictual parental separation or divorce, and the negative psychological outcomes following trauma (see section 3.4 for a full comparison).

Children react to trauma in varied ways and their reaction is not always similar to that of an adult. A young child may not have the language abilities to adequately express themselves or to describe their experience and may resort to hostile, aggressive or destructive behaviour (Eth & Pynoos, 1985; Dyregrov & Yule, 2006). Some children will withdraw in to themselves and engage in symbolic play about the event. The way a child reacts to trauma will often depend on their own parent's reaction, with children of calm parents tending to feel open to speak about and process the event, and conversely, children of parents who tend to panic about the event, quickly learning not to mention the event (Dyregrov & Yule, 2006). This highlights the importance of parental involvement in the treatment of children who are having difficulties coping following a trauma.

Psychological issues that can arise from the experiencing of a trauma can include symptoms of post traumatic stress, depression, anxiety and behavioural problems (Hetherington, 1991). Symptoms of post traumatic stress can be particularly debilitating

and evidence has shown that when left untreated a significant proportion of PTSD diagnoses persist for many years (Morgan et. al., 2003). The experience of a child with post traumatic stress symptoms will often include reoccurring and distressing recollections of the event that are often observable during the child's play. This is typically accompanied by distress and physiological arousal. The child may also avoid reminders of the trauma and/or become disengaged from their surroundings, have trouble sleeping, be irritable or angry and may be easily startled. A child who has undergone trauma may also experience increased depression with reduced interest in their surroundings, sleep problems, lower energy levels, and feelings of worthlessness and concentration problems.

Several factors will impact on a child's ability to adjust following a conflictual parental separation or divorce. For example, the impact of conflict on the child is reduced when they have a positive, warm and communicative relationship with at least one parent that involves consistent discipline and boundaries (O'Connor, 2003; Hetherington & Stanley-Hagan, 1999; Rushena, Prior, Sanson, & Smart, 2005; Wallerstein & Kelly, 1980). Research has shown that such factors may be easily improved and can result in more positive outcomes for children of divorce, when strategies aimed at improving these factors are taught in parents (Martinez & Forgatch, 2001; Pedro-Carroll & Cowen, 1985; Wolchik, et. al., 2002). Parents who praise their child and avoid making demeaning comments about the other parent can help their children to avoid the negative psychological outcomes of conflictual parental separation or divorce (Katz & Gottman, 1997) again highlighting the usefulness of having parents involved in any therapy the child might undergo to address stress symptoms. Children also benefit from a decrease in frequency and intensity of conflict (Johnston et. al., 1987), and an increase in conflict resolution (Cummings et. al., 1989; Cummings & Davies, 1994). Parents need to be made aware that their children will fare worse when the conflict is focused on the child (Buchanan et. al., 1991) and when they model poor behaviours for their child, such as aggression (Katz & Gottman, 1997). The above mentioned factors require consideration when designing any form of intervention for these vulnerable children and such factors highlight the importance of having a parent focused component during therapy. Children can also aid in their own adjustment following a conflictual parental separation or divorce, by actively seeking support from others (Lepore, Silver, Wortman & Wayment, 1996; Pennebaker, 1989; Silver, Boon & Stones, 1983). The sharing of

details about their traumatic experience can help the child to cognitively process the event, a finding that suggests the potential usefulness of utilising a group work component in interventions for these children.

The most well researched form of treatment for children showing stress reactions following trauma, is that of Cognitive Behavioural Therapy (CBT). Elements of CBT, including the use of cognitive therapy, stress inoculation training, gradual exposure and systematic desensitisation, have been shown to successfully treat PTSD, anxiety, depression and behavioural problems in children who have experienced sexual abuse (Cohen, Deblinger, Mannarino & Steer, 2004; Cohen & Mannarino, 1996, 1998a, 1998b; Cohen, Mannarino & Knudsen, 2005; Deblinger, Lippmann & Steer, 1996; Deblinger, Mannarino, Cohen & Steer, 2006; Deblinger, Stauffer & Steer, 2001; Deblinger, Steer & Lippmann, 1999; King, et. al., 2000), childhood traumatic grief (Cohen, Mannarino & Knudsen, 2004b; Cohen, Mannarino & Staron, 2006b), witnessing of domestic violence (Tucker, 2010), child abuse (Feather & Ronan, 2006, 2009; Runyon, Deblinger & Schroeder, 2009) and varied single incident traumas (Morsette, et. al., 2009; Shoostary, Panaghi & Moghadam, 2008; Smith, et. al., 2007). These studies have provided support for the usefulness of involving at least one parent in the therapeutic process as well as the use of child group sessions during therapy. Interestingly, although there is evidence that abused, neglected or highly anxious children have a tendency to be better at recognising angry faces rather than happy faces (Pollack, Cicchetti, Klorman, & Brumaghim, 1997; Pollack et al., 2001), and to rate neutral faces as being either sad or angry (Leist & Dadds, 2009), no research has examined this phenomenon either throughout the therapeutic process, or specifically in children from high conflict parental separation or divorce. This would be an important inclusion in research involving children of high interparental conflict exposure, given that these children often report the high levels of anxiety (Weir, 2006) that are associated with altered facial recognition abilities, and evidence suggests that these abilities may relate to effective child adjustment.

To our knowledge, no research has ever been carried out that has specifically examined the efficacy of CBT methods for treating children traumatised by high level parental conflict. It has been suggested that the above mentioned CBT methods may be usefully applied in children following a wide range of trauma types (Cohen, Deblinger,

Mannarino & Steer, 2004). This was suggested given that in a study of sexually abused children, some 90% reported some other form of trauma- yet even though the CBT program focused primarily on treating the sexual abuse; most children no longer met PTSD criteria following treatment completion (Cohen, Deblinger, Mannarino & Steer, 2004). We cannot however, assume that CBT methods are effective at treating fear reactions in children following a conflictual parental separation, without carrying out a controlled clinical trial. For this reason, the author and associated research team, decided to conduct a pilot study investigating the efficiency and efficacy of a manualised CBT - based treatment program for children aged 5 to 13 years, showing fear reactions following a conflictual parental separation. This specific age group was chosen given evidence that younger children, who face a greater number of developmental tasks, may be more susceptible to negative outcomes following conflictual parental separation or divorce (Wallerstein & Lewis, 1998; Zill, Morrison & Coiro, 1993), than might older children.

The current author and research team developed a comprehensive, seven week manual based treatment for children aged 5 to 13 from conflictual parental separation that involved a combination of individual child CBT sessions, combined parent/child sessions, and child group CBT sessions (Appendix A). This combined parent and child focus was chosen based on evidence that the behaviour of the parent, and the relationship they maintain with their child, is pivotal in providing the child with the resources needed to adjust adequately following a conflictual parental separation or divorce (Bandura, 1973; Cummings et. al., 1989; Cummings & Davies, 1994). In addition, a reduction in conflict and its intensity and an increase in conflict resolution (which has been shown to improve child outcomes; Cummings & Davies, 1994; Cummings & Davies 2002; Jourilles, et. al., 1991), would require the active involvement of one parent. The child group component was included given evidence that child outcomes are improved when they have support and can share their experiences with others (Baker, 1987; Lepore, Silver, Wortman & Wayment, 1996; Pennebaker, 1989; Silver, Boon & Stones, 1983).

The child CBT program involved several components. Stress Inoculation Training (SIT), was provided in order to encourage a reduction in physiological and emotional stress in the children. SIT training was provided prior to beginning gradual imaginal exposure, so

that the children would have the necessary skills to regulate and minimise their stress during exposure. Cognitive therapy was also employed, that aimed to target any maladaptive thoughts or ‘stinking thinking’ the children might have been experiencing. Each of these techniques have a solid evidence base (refer to sections 5.2 and 5.3).

The children also completed a short concurrent Anger Management Module (Appendix B), which the parents were also involved in (Appendix D). This anger management component was included due to the high rates of anger and aggression reported in children following conflictual parental separation, as well as other forms of trauma (Block, Block & Gjerde, 1986; Cummings & Davies, 1994; Harrist & Ainslie, 1998; Johnston, Gonzalez & Campbell, 1987; Weir, 2006).

The research team also developed a 5 week parent group manual, to be run concurrently with the child sessions (Appendix C). The parents group involved some CBT elements, but was predominantly a means of providing information and support to parents rather than a treatment for the parents per se. The parents groups focused on providing information to parents on how they could improve outcomes for their child. This included discussion of how to reduce their child’s exposure to conflict, how to avoid conflict or at least reduce the intensity of the conflict, how to model appropriate coping behaviours for their child as well as how to encourage a positive, warm and responsive relationship with their child. Parents were also taught skills in how to maintain consistent discipline and boundaries.

It was thought that the child CBT program, coupled with the concurrent parent group, would provide optimal opportunity to break down the maladaptive coping cycles that have been illustrated in Grych and Fincham’s (1990) model of the cognitive-contextual framework of child responses to parental conflict (refer to section 4.3). The CBT program aimed to reduce learnt fear responses (a distal cue), reduce negative and maladaptive thinking (proximal cues), which would in turn promote healthier primary and secondary processing of information during parental conflict. This more adaptive and accurate processing and perception of information, aimed to result in the use of more appropriate coping behaviours in the children.

A Bibliotherapy control group was also utilised as a comparison condition. Rather than having a wait-list control, the research team decided on giving a self-help book (Mom's House, Dad's House; Ricci, 1997), which would be very similar to the Non-Directive Supportive Therapy (NST) offered in other research (Cohen & Mannarino, 1996, 1998b; Deblinger, Stauffer & Steer, 2001).

Chapter six will present the specific aims and hypotheses of this research project, followed by a comprehensive review of methodology and measures. Results will then be presented, followed by a comprehensive discussion of findings. This research was supported by funding generously provided by the Telstra Community Development Fund.

6.2. Aims and Hypotheses.

The current research aimed to examine the impact of a comprehensive 7-week Trauma-Focussed CBT program on measures of PTSD, depression, anxiety, perception of interparental conflict, internalising behaviour, externalising behaviour, and facial emotion recognition in a sample of children showing fear reactions following a conflictual parental separation. Based on prior research findings to date, the following hypotheses were made:

1. It was hypothesised that children taking part in the CBT program would show significantly better improvement over children taking part in the Bibliotherapy condition, on measures of PTSD (Children's PTSD Symptom Scale-Revised (Self-Scored) (CPSS); Foa, et. al., 2001), depression (Children's Depression Inventory (CDI); Kovacs, 1981, 1985, 1992), anxiety (The Revised Children's Manifest Anxiety Scale (RCMAS); Reynolds & Richmond, 1978), perceptions of interparental conflict (Children's Perception of Interparental Conflict Scale (CPICS); Grych & Fincham, 1992), internalising behaviour and externalising behaviour (Child Behaviour Checklist (CBCL); Achenbach, 1991), feelings of being sad/depressed (as measured by card #1 of the Pictured Feelings Instrument (PFI); Shack Stone, 2004) and feelings of being

happy/content (as measured by card #2 of the Pictured Feelings Instrument (PFI); Shack Stone, 2004), from intake to post-treatment assessment.

2. It was hypothesised that these therapeutic gains made by children taking part in the CBT program, would be maintained at the three-month follow-up assessment.
3. It was further hypothesised that therapeutic gains observed in children taking part in the CBT condition, would not only be of statistical significance, but of clinical significance also.
4. It was hypothesised that parental ratings of happiness with their relationship with their child, would be related to more positive outcomes at post and three-month follow-up assessments.
5. It was hypothesised that children from conflictual parental separation, would be significantly worse at accurately identifying facial emotions on the Pictured Feelings Instrument, in comparison to the normative sample statistics reported in the Pictured Feelings Instrument manual (Schack Stone, 2004).

6.3. Methods

6.3.1. Participants

Participant Recruitment.

Participants were recruited via several methods. Initially, the assistance of PRISMS (Providing Resources for Independent Single Mothers after Separation), a community organisation was obtained. An advertisement was placed on the PRISMS website detailing the research program. Several packages containing flyers and information on

the program were also posted out to over 200 primary schools in and around Melbourne, as well as approximately 60 community centres or family assistance agencies that deal with separated families. The investigators also attended meetings of the Family Mediation Centre to provide flyers and information to psychologists and social workers in the field, who might be able to assist with recruitment of suitable families into the program.

Eligibility Requirements.

Parents interested in taking part in the program completed a 20 minute telephone interview, to ensure that the program was ideally suited to their situation. Eligibility criteria included: that the parents were formally separated, that they were the legal carer of their child/children on the day that therapy was held, that the relationship with their ex-partner must have been regarded as having been conflictual, there must be no current physical violence between the parent and the ex-partner, and no physical violence being perpetrated against the child/children, the child/children must be aged between 5 and 13, the family must be able to commit to the entire program including the three-month follow up, they must have no profound disabilities that would make it inappropriate to take part in the program, and parents must be able to read English at a competent level.

Parents were also asked questions about their children's symptoms related to the prior conflict and that have occurred at least twice in the past week. These included: "Had upsetting thoughts or memories about the conflict," "Had upsetting dreams about the conflict," "Acting or feeling as though the conflict were happening again," "Feeling upset by reminders of the conflict," "Had bodily reactions," "Had difficulty falling or staying asleep," "Been irritable or had outbursts of anger," "Had difficulty concentrating," "Appeared to have a heightened awareness of potential dangers to both themselves and others," and "Been jumpy or easily startled at something unexpected." For the child to be eligible to take part in the program, the parents had to have indicated at least one of the above mentioned symptoms, and this had to be clearly related to witnessing the prior conflict. Refer to Appendix E for the full eligibility screening instrument.

Ineligible Families.

Some parents who enquired about the program were not eligible or able to take part. There were families who lived too far away to attend (3 parents, 4 children), had children who were outside the specified age range (5 parents who between them had 12 children who were outside of the age range), couldn't meet the time commitment of weekly therapy sessions (1 parent, 1 child), were for reasons unknown no longer interested (3 parents, 3 children) and one child did not take part due to a diagnosis of Autism that was already being treated by another therapist. Families who were deemed ineligible to take part in the program were offered referral advice to other more appropriate services.

Randomisation.

The initial plan to randomly allocate families to either condition was abandoned due to an underwhelming response to our recruitment efforts. In order to have enough families available to form adequate child and parent therapy groups, we had to instead adapt a stratified design. This involved placing the first five families that approached us into the Bibliotherapy condition, the next five into the CBT condition and this repeated until the number of participants in each condition was sufficient to meet our study design. This meant that three successive 'rounds' of therapy were conducted by the investigators, with five children taking part in each round.

If we had not used this stratified allocation, there would have been several families waiting long periods of around two months, before enough families were randomly allocated to the treatment condition to form adequately sized therapy groups. It would have been unethical to leave highly distressed families waiting this long to receive assistance.

Families were not aware of their group allocation until after having completed their intake assessment. This style of randomisation was thought to be the most appropriate

given the circumstances, and given that the investigators had no control over when each family first contacted the study team, the design was still inherently random.⁶

Sample Characteristics.

Child Demographic Information.

A total of 14 children took part in the Bibliotherapy condition, and 15 in the therapy condition. Child gender was relatively equally distributed within the Bibliotherapy condition (Female = 6, Male = 8), but was slightly skewed in the therapy condition (Female = 5, Male = 10). Children's ages differed significantly between groups (Bibliotherapy: Min = 6, Max = 13, $M = 9.43$, $SD = 1.99$; Therapy: Min = 5, Max = 10, $M = 6.93$, $SD = 1.44$; $F = 12.51$, $p < .01$). Please note that despite the significant difference in age between treatment groups, it was not possible to run ANCOVA's with age as the covariate. This was due to there being no correlation between age and scores on any measure, making it inappropriate to run ANCOVA's in this way. Instead, repeated measures ANOVA's were run and these will be described further in sections 6.4.1 and 6.4.2.

A total of 17.24% of the children taking part had visited a psychologist in the past six months, 6.90% had visited a social worker and 6.90% had visited a counsellor. Over their lifetime, 34.48% of the children taking part had seen somebody for professional help regarding emotional problems.

Parent Demographic Information.

A total of 8 parents took part in the Bibliotherapy condition, and 11 in the therapy condition. All parents were females except for one male in the Bibliotherapy condition. The imbalance of parents and children in each condition was due to some parents having more than one child taking part. Parent age did not differ significantly between conditions (Bibliotherapy: Min = 28, Max = 43, $M = 38.25$, $SD = 5.90$; Therapy: Min = 29, Max = 48, $M = 37.30$, $SD = 5.70$; $F = 0.12$). Months since formal separation or

divorce did not differ significantly between groups (Bibliotherapy: Min = 12, Max = 84, $M = 37.33$, $SD = 27.29$; Therapy: Min = 0, Max = 72, $M = 29$, $SD = 19.57$; $F = 0.63$). No data was collected on the length of time since one parent moved out of the family home, the length of time since conflict began, or the current level of conflict between the parents.

Data indicated that parents were mostly highly educated with 31.58% having completed tertiary education, followed by 21.05% having completed secondary school. The majority of parents worked in white collar occupations (31.58%) followed by professional occupations (21.05%). Over two-thirds of parents (68.42%) had a household income of less than \$40,990 per annum. In the majority of cases, three people were dependent on the household's income (57.89%).

Just under half of parents (47.37%) had seen a psychologist in the past 6 months, with only one parent who had sought psychiatric help, two parents who had visited a social worker, and three parents who had sought the assistance of a counsellor. A total of 84.21% of parents had sought some sort of professional help for emotional problems throughout their lifetime.

The majority of parents described their current relationship status as separated (42.10%), followed by divorced (36.84%), with equal numbers describing themselves as in a de facto relationship (10.53%) or single (10.53%). Over half of parents (52.63%) reported that they were currently either seeing or dating other people. Most parents reported that they had wanted to separate from their ex-partner (78.95%). Just over one-third (36.84%) of parents had attended mediation with their ex partner, with only 24% of these actually completing mediation.

Only 15.79% of parents were under-going legal action regarding divorce proceedings, 21.05% regarding property settlement, 15.79% regarding child support arrangements, 21.05% regarding child custody arrangements and 15.79% regarding domestic violence or restraining orders.

Almost two-thirds (63.16%) of the parents reported having a lot less money to spend on themselves since the separation. A total of 68.42% of parents were currently receiving

child support payments. All parents of the Bibliotherapy condition reported that they had completed reading the provided book.

6.3.2. Procedure

A total of three rounds of therapy had to be completed in order to obtain sufficient participant numbers. Parents phoning to ask about the research were sent out the information sheet and once read, completed an eligibility assessment on the telephone in order to assess that the research was ideally suited to them. Provided that the family was then deemed suitable, they attended the Brain Sciences Institute for an intake assessment. Those families who were unsuitable for inclusion in the research were offered referral advice. The intake assessments, as described in the materials section, were identical across treatment conditions for both the parents and the children. The parents were always left in a quiet room on their own to complete their assessment package in privacy. Each child completed their assessment package with a trained therapist. Assessments for both parent and child took approximately one hour to complete. Following the assessment, the parents were given an envelope containing a small piece of paper that indicated whether they would be part of the CBT condition, or the Bibliotherapy condition. The details of that condition were then explained in full to the parent. If they were part of the Bibliotherapy condition the parents were immediately given the book to take home and begin reading. Those who were part of the CBT condition were advised of the proposed therapy start time and dates, and were then phoned at a later stage to confirm these details.

The CBT Condition: CBT Therapy Programme, Weekly Summary.

WEEK ONE CBT.

- Combined Parent and Child Session (60 minutes)

Goals: To provide information to the parent and child on the program and what they will be doing over the course of the 7 weeks, to discuss confidentiality, to affirm the role of the parent as a ‘co-therapist,’ to get to know the child better, to develop an understanding of the child’s needs and hopes and to set up a regular time each week for

the parent and child to work on their homework together. Time will be spent alone with the parent to clarify the focus and purpose of the treatment programme. During this time, parents will have the opportunity to identify a specific problematic behaviour that they have observed in their child, which is specifically related to the trauma of the conflictual parental separation. The parent and therapist will devise a plan to encourage the child to respond more adaptively to the stressor, by setting up some form of reward system that will involve a 'gold stars chart' and a list of rewards that the child will work towards. Time will also be spent alone with the child to explore with them what they would like to be different in their life and how the program might work towards their own goals. The children will also have the opportunity to talk about the things in their life that they wish were different, so that the program may be shaped to work towards their individual goals. The parent will then rejoin the session with the child and therapist so that the important role of the weekly homework can be discussed. This week's homework involves the parent and child choosing a treat for themselves as a reward for coming along to the first session.

WEEK TWO CBT.

- Child Individual Therapy Session (60 minutes)

Goal: To introduce the discussion of feelings. This session begins with a review of the homework set for last week – did the child receive a reward for coming to the session? If so, what was it? Did the child earn any stars or receive one of the rewards on their rewards chart for good behaviour? The therapist will discuss with the child, the link between how what we think influences what we feel. The concept of 'stinking thinking' will be introduced: *–That some thoughts are inaccurate and make us feel bad. There is usually a more useful way to think about a situation, that won't make us feel bad inside.* Scenarios or stories about fictional children will be told and the children will be asked to identify the stinking thinking in that particular scenario. The children will be asked for examples of positive thinking that could replace the stinking thinking in each scenario. Home work for the child this week is to identify an instance of their own stinking thinking and to write it down or draw a picture of it to bring along next week.

- Parent Group 1 (120 minutes)

Goals: To introduce parents/therapists to each other, and discuss content that will be covered throughout the weekly parent group sessions. The therapists will first lead introductions amongst group members before discussing with parents that the groups are designed to focus on helping the children to adjust following the conflictual parental separation or divorce. Emphasis will also be placed on the purpose of the group being to learn new parenting skills, reduce conflict with their ex-partner and learn ways of supporting their children, rather than the group acting as a platform for the denigration of the ex-partner. Confidentiality and group rules such as being punctual, making attendance each week a priority, completing homework assignments and listening respectfully to others, will also be discussed. Parents will be asked to share what it is they hope to gain from the group sessions. The therapists will encourage the parents to discuss their child's problematic behaviour that was identified during the combined parent/child session in group one, and whether any progress was made in reducing this behaviour during the past week via use of the gold stars chart or rewards list. The therapists will then talk about research that indicates that children have poor outcomes when exposed to parental conflict, in order to highlight the importance of keeping their children away from any conflict that does occur. The parents will then be asked to identify what some of the concerns are that their children might be having since the separation or divorce occurred. The idea is for parents to examine what the experience might be like for their children and how their children might perceive all the changes that are occurring. Parents will receive handouts and will watch a DVD that describes some of the issues children face during and following separation or divorce. Parents will be asked to identify feelings that they observe in their child by pointing out to the child – "You seem to be feeling angry/happy/sad today." This exercise can help the children to identify their own feelings which will aid them in completing their homework tasks in the coming weeks. Parents will also be encouraged to praise their child when they accurately identify an emotion – i.e. if the child tells the parents they are feeling scared / sad etc. Parents should also identify and express their own feelings as a means for modelling this behaviour for their child. This way, the child learns it is a positive and normal experience to talk about their feelings. The parents will also learn about the concept of 'stinking thinking' so that they can help their child identify any examples of 'stinking thinking' they may have prior to next weeks session. Parents will be asked to identify one positive aspect of their child

before the group concludes for the week. Homework for the parents this week will involve practicing the skills taught during this week's session, completing some hand outs and helping their child complete their own homework.

WEEK THREE CBT.

- Child Group Session (120 minutes- there is no individual child/therapist session this week)

Goals: To introduce the children to each other and the group therapists, to explain the reason why they are attending each week, to establish group rules regarding confidentiality, listening and behaving appropriately during group time. This session will begin with the children receiving name tags and playing some games designed to facilitate introductions between the children. The therapist will then ask the children what they think are some important rules to have for the group, so that everyone feels comfortable. Rules such as making sure everyone has a chance to speak uninterrupted, treating others nicely, and confidentiality will be included. The therapist will explain to the children that the things they say during the group will remain confidential unless someone says something that indicates that someone is in danger- in which case confidentiality may need to be broken in order to keep that person safe. The group will then be asked questions about parental separation and divorce, such as "how long has it been since your parents separated?" "Have things been better or worse since they separated?" A list will be made indicating which things have improved and which things have worsened for the children. The children will then be asked to call out the feelings they know of and to say whether the feeling is a good feeling or a bad feeling. The therapist will then ask "How can you tell when you are feeling (insert feeling)? What does your body feel like and how do you act when you feel that way?" This will be done in an effort to demonstrate to the children that emotional feelings can have an impact upon their physiological feelings. The children will then be encouraged to talk about some of the "stinking thinking" examples that they thought of for their homework task from the last session, and how this "stinking thinking" made them feel. The therapist will then ask the children to share some of the coping strategies they use when they are feeling bad about the parental separation and will draw attention to the more positive and constructive suggestions made by the children. The therapist will then lead the children in a form of Stress Inoculation Training (SIT) called calm breathing. This

form of breathing involves breathing deep in to the diaphragm and exhaling slowly. The therapist will then lead another form of SIT, namely, progressive muscle relaxation. The therapist will read out a script that encourages the children to tense and then relax one set of muscles at a time until the entire body feels relaxed. The scripts have been specifically designed to appeal to children and the child will receive a small card to direct them in how to practice these skills on their own (for children who cannot yet read, the parent can use the card to help the child practice their SIT skills). The children will be told that they can use these two forms of SIT whenever they feel tense or stressed. This week's homework involves practicing the two forms of SIT training.

- Parent Group 2 (120 minutes)

Goals: To provoke discussion about the negative impact of parental conflict on children and to highlight the need for change in the parent's behaviour, in order to observe a change in the child's behaviour. This week's session will begin with discussion of last week's homework and how parents felt they went. The therapists will then discuss with the parents ways in which they can increase their child's sense of stability and security, such as by maintaining routines, keeping change to a minimum, showing the child that the parent is coping, being consistent with discipline and their interactions with their child, reassuring the child that they are loved, avoiding saying demeaning things about the child's other parent and by keeping the child away from any conflict. Parents will be discouraged from relying on their child for their own emotional support, and will instead be encouraged to seek support from other adults, given that children do not have the emotional or cognitive capacity to act in a supportive role for their parents. The therapists will then discuss the benefits that having a close and supportive relationship with their child, can have on increasing positive outcomes for the child following separation or divorce. Several methods for improving the parent – child relationship will be provided, including: 1) having special family _fun – time, ' 2) making time for one – on – one time between only the parent and child where the parent is focused solely on the child, 3) making an extra effort to _catch' the child being good and pointing out the good behaviour to the child and 4) making effort to listen to the child, think carefully about what the child is saying, and respond effectively to the child. Parents will also be advised on how much information the child needs to know (based on their age) about the reasons for the parental separation or divorce. Therapists will advise parent to tell children four key messages: 1) A simple statement that the marriage didn't work – _We

tried very hard but we couldn't make our marriage work,' 2) A message that you still love your child – 'I don't love your Mum anymore, but I love you as much as always and I will always love you. Children don't get divorced. You still belong to both of us,' 3) Reassurance that the divorce wasn't the child's fault – 'Nothing you have done or could've done affected our decision,' 4) Reassurance about the future – 'I'm never going to leave you or stop loving you. I'll always be there for you.' Finally, the parents will hear in detail about the SIT training that the children will be doing in their sessions this week. Parents will also learn the calm breathing technique and hear the SIT relaxation scripts, so that they can help their child to practice these skills in the coming weeks. Homework this week will involve the parent implementing some of the strategies for improving the parent/child relationship, helping their child with their homework and looking out for 'stinking thinking' in their child.

WEEK FOUR CBT.

- Child Individual Therapy Session (60 minutes)

Goals: To discuss the idea of 'imaginal exposure' with the children on a basic level. Children who have been through a trauma will often develop unhealthy patterns of avoidance in order to evade unpleasant reminders of the traumatic experience. The idea of this session is to gently begin to encourage the children to manage their feared memories, and give the children the skills to cope when confronted with a reminder of the trauma. This will be done by having the child talk about a traumatic event (one chosen by the child as being particularly distressing) in increasing detail over the coming sessions, while utilising their SIT skills. This way, the children learn to speak about their experiences without feeling overwhelmed and will become better at coping with reminders of the trauma. The children may also gain a better understanding of their experience and any incorrect or distorted cognitions can be addressed by the therapist. In this session, the children will be introduced to the idea that when they repeat their stories of witnessing or being involved in parental conflict, they will start to feel less upset about those memories. The therapist will then choose one of two different analogies to help explain the importance of learning to cope with

traumatic experiences. The following script will not be followed verbatim by the therapists, but rather, the therapist will use the example in an age appropriate manner to convey the analogy to the child. The first analogy is called the ‘_trauma box’ analogy:

—Very often, after a trauma we tend to pack away into a box the event and file away what happened, putting it to the back of our mind. We then use a little strength to keep the lid tightly closed and try to leave it undisturbed. However, over time, two things happen. Firstly our strength begins to wane and it becomes more of an effort to keep it sealed. Secondly, due to the pressure, the box begins to lose its shape, if you like, and small cracks begin to appear. What we experience as symptoms (e.g. re-living the trauma and having disturbed sleep) is like the content of the box spilling out through these cracks. This may scare us and we go on to avoid anything that reminds us of the trauma and try to stop thinking and talking through exactly what happened and how we felt. In this way the content of the box becomes a “ghost” which we have learned to fear.

What we will be doing during some of the therapy is to open the box and inspect the content for what it really is. In this way we can talk through what happened and how you felt. However, this will be done in a precise way so as to avoid as much suffering as possible. In this manner we will be inspecting the “ghosts” that have been created and throwing away any un-adaptive and distressing beliefs you may have about the event. We find that once the trauma has been dealt with in this manner the symptoms become much less severe and less frequent.”

The second analogy the therapist may choose to use is the ‘_digestion analogy:’
—Sometimes we eat something which may cause us indigestion. It may lie in the bottom of our stomach and just weigh us down and we can prove it is still there by being sick. To get rid of the item we can either expel it or digest it. We cannot expel a trauma because we cannot take back what has happened, but we can digest it and “integrate” it into who we are. It is thought that traumas that still cause problems later on, have not been integrated into the person’s self-concept

and this should be one of the goals of the therapy. What we will be doing is to integrate the trauma into who we are so it no longer –sticks out”. We will be doing this by progressively desensitising you to the memory and integrating the trauma. This process is sometimes referred to as HABITUATION.”

The children will then have a go at telling their story on a basic level and they can use pencils and paper to draw parts of their story if desired. In this session the child will not be pressured or challenged to provide additional detail. The therapist will gently encourage and prompt the child with phrases such as “I know this is difficult, but you are doing a great job.” The child will then be asked to begin work on a book, where they can draw pictures and tell the story of their traumatic incident. The child might start by drawing a title page for their book and decorating the page. This way the child can begin with smaller and easier aspects of their story, and gradually add more detail to both the narrative and to the stories that accompany the narrative. The session will be completed with ‘grounding’ whereby the therapist will ensure the child is comfortable and relaxed prior to leaving the session, by practicing the calm breathing and progressive muscle relaxation with the child. The child’s homework this week involves having a small reward for starting the exposure component of the program, to sit down with the parent and discuss what they did in their session this week, and to continue practicing their SIT skills.

- Child Group Session (60 minutes)

Goals: To practice identifying ‘stinking thinking’ in fictional scenarios presented to the children, with a focus on inflated perceptions of control and responsibility. The idea of this group session is to further demonstrate to the children the link between thoughts, feelings and behaviours. Rather than trying to do this in a didactic manner (which children may find confusing), the links will be illustrated through several hypothetical scenarios. The first scenario is as follows:

A girl called Sally is new to her school, she has been there about a month, and she has made some new friends. One day she sees one of her new friends in the playground and starts to walk over to talk to her. The other girl started walking in the opposite direction, and when Sally yelled out to the girl, she didn’t turn around or reply.

- *What might Sally be feeling? What do you think Sally is thinking to feel this way? What might she do in this situation (to feel better)?*
- *What are some other examples of what Sally might be thinking?*

After the children come up with answers to the above questions, the therapist will ask the children which of the thoughts are ‘stinking thinking’ and which thoughts are ok. The children’s attention will be drawn to the fact that some possible thoughts that Sally may have had could lead her to feel badly, but others might lead her to feel ok or happy. This way, the children learn that the way they choose to think about a situation, will impact on how they feel and behave. Children were then taught how to challenge stinking thinking, for example, coming up with other more positive ways to think about scenarios. The children then also discussed what anger looks like in themselves and others, and how to identify the emotional and physical feelings they experience when they start to get angry.

- Parent Group 3 (120 minutes)

Goals: To provoke discussion of ways in which the parents can minimise their children’s exposure to parental conflict. The therapists will discuss the importance of reducing child exposure to interparental conflict, including mention of the deleterious effect of conflict on the child’s sense of safety, security and the child’s capacity to meet their developmental milestones. Parents will be encouraged to discuss the different conflict styles of being avoidant, forceful, accommodating, compromising or collaborative. In order to assist the parents in reducing the frequency of conflict exposure for their child, the parents will be asked to identify when they are most likely to have conflict, how their children respond to being caught in conflict, what gets in the way of them communicating effectively with their ex and what they feel they can do about it. Parents will be informed about the imaginal exposure that their children will be working on in their individual therapy sessions and will also be informed about how their child might respond following the exposure. Parents will also be aware of the hypothetical scenario being discussed in this week’s child group session, and the links that are being illustrated to the children about the related nature of thinking, feeling and behaving. Homework this week for the parents will involve assisting the child with their homework, practice using the tips provided in today’s session, continuing work on

improving the parent/child relationship and providing support to the child following the exposure component of this week's session.

WEEK FIVE CBT.

- Child Individual Therapy Session (60 minutes)

Goals: The aim this week is to continue the imaginal exposure at a level appropriate to the individual child. The child will be asked to tell their story again and add more detail to the story book that they began work on last week. The therapist will (if appropriate) ask the child for additional detail on aspects of the story where the child seems to be avoiding going in depth. The therapist will interrupt the story at times to ask questions about how the child was feeling at that particular point and what the child was thinking. Any instances of 'stinking thinking' will be challenged and the therapist will ask the child if there is a better way that they might think about that particular aspect of the event. The idea is to lead the child to develop more rational perceptions surrounding their experience, with an emphasis on ameliorating any self blame the child may be feeling for the conflict. This approach may also give them skills to help them cope during any future instances of conflict. Prior to completing the session the therapist will practice the SIT skills with the child and ensure that the child is comfortable and relaxed before leaving the session. This weeks homework is for the child to sit down with the parent and tell them what they did in this weeks session, and to practice the SIT training.

- Child Group Session (60 minutes)

Goals: To expand on the idea of stinking thinking and how it relates to what we feel inside. Two scenarios involving stinking thinking will be presented to the children and they will work as a group to come up with several examples of possible stinking thinking, then of possible positive thinking. The scenarios are as follows:

- 1) *Tom has just found out that he has failed a maths test at school. He usually does OK in tests, but maths is the subject he finds hardest.*

Questions:

- *What might Tom be feeling? What do you think Tom is thinking to feel this way? What might he do in this situation (to feel better)?*
- *What are some other examples of how Tom might be thinking?*

2) *Judy and her sister are very close, and care a lot about each other. Judy usually looks after her sister when she needs help, or when their parents aren't nearby. She likes to take care of her sister. Judy has just found out that her younger sister is unwell, and needs to go to hospital. Judy feels guilty.*

Questions:

- *We know what Judy is feeling in this situation; she is feeling guilty about her sister going into hospital. What do you think Judy is thinking to feel this way? What might she do in this situation?*
- *What are some other examples of how Judy could think about this situation?*

The children will answer the above questions as a group and will determine which thoughts are 'stinking thinking' and which thoughts are ok. The children will then be asked how each thought would make them feel inside, in order to demonstrate that the positive thoughts would make them feel much better than the stinking thinking examples. The children will again discuss anger and how they might implement their SIT training to avoid angry outbursts. They will also discuss how stinking thinking may contribute to feelings of anger. The homework from the group session this week will involve the child identifying an example of 'stinking thinking' that they will bring along to the next session where the child will be encouraged of another more positive thought they could instead have about the situation.

- Parent Group 4 (120 minutes)

Goals: To identify how their role as a parent has changed since the separation and discuss this as a group. Therapists will this week discuss with the parents the importance of building a 'parenting coalition.' Parents will troubleshoot some of the

common impediments to having a collaborative co-parenting approach with their ex – partner. Parents will also be encouraged to assist their child in maintaining regular meaningful contact with the other parent (only in the case that contact with the other parent is safe), and will be informed that children who maintain such a relationship fare better in the longer term. The therapists will discuss ways in which the parents can support their child’s relationship with their other parent. The parents will then be informed about the content being covered in the child group and individual session this week. Homework will include completing some worksheets about improving the parenting relationship, and assisting the children with their homework.

WEEK SIX CBT.

- Child Individual Therapy Session.

Goals: To further explore the imaginal exposure, while challenging stinking thinking where appropriate. The child will expand further on their story during imaginal exposure and the therapist will again challenge ‘stinking thinking’ and encourage the child to find more useful and constructive ways to think about the event. SIT skills will be practiced again and the children will be asked about possible future events related to their parent’s conflict, that they feel anxious or worried about. The therapist will then work with the child to come up with a plan on how the child could best deal with the situation if it does eventually occur. In the case of the child being fearful of another incident of exposure to interparental conflict, it might be advisable to encourage the child to remove themselves from the situation by going in to another room, or distracting themselves with a game or a book. Different options will be discussed with the child and use of the SIT training skills will be incorporated in to the child’s plan. In the meantime the child will be encouraged to discuss the potentially upsetting future event with one or both parents (if appropriate), so that the parent is aware of the child’s concerns and may even be able to help avoid the situation from occurring.

- Child Group Session (60 minutes)

Goals: to further discuss stinking thinking examples and challenge these thoughts. This is the children’s final group session. The children will be presented with one final scenario to consider:

It is Harry's birthday on the weekend coming up and he is having two of his best friends over to play. One of these friends is Harry's neighbour; the other friend is a boy from school. These two boys don't know each other very well, but they always fight when they play together. Harry is starting to feel worried and is laying awake at night thinking of ways that he can make his friends get along.

Questions:

- *We know what Harry is feeling in this situation, he is feeling worried about his friends fighting. We also know what he is going to do in this situation, he is spending his time worrying and thinking about what he can do to make them get along. What do you think Harry is thinking to feel this way? (that it is his responsibility that his friends get along).*
- *What are some other examples of how Harry could think about this situation?*

The children will answer these questions as a group and the therapist will point out that more positive ways of thinking might have led Harry to feel much better about a situation that was not within his control. The aim of this session is also to discuss the children's own examples of their stinking thinking that they gathered for their last week's homework and then as a group come up with more effective ways that child could think about the situation. The children will be encouraged to ask themselves:

- *Is there another way to look at this situation?*
- *Is that thought accurate?*
- *Is that thought helpful?*
- *What would I say to my best friend if they were in this situation?*

The children also discussed examples of their own anger in the last week, and if there was any stinking thinking that provoked their anger. The children discussed why anger doesn't help the situation, and how once we are angry, people are less likely to listen and respond effectively to us. The children will have the chance to say farewell to other members of the group prior to the group concluding.

- Parent Group 5 (120 minutes)

Goals: To discuss how the parents went with implementing the positive parenting principles learnt in the last session, and troubleshoot any difficulties experienced. The parents will talk about different parenting styles and the importance of consistent discipline, even now that there is one less parent in the household to help maintain the same consistent level of discipline as before the separation or divorce. The therapists will discuss common reasons for child misbehaviour including: not receiving enough positive attention, ‘acting out’ or becoming angry because they don’t know how else to express themselves or the child being unclear about what the rules are and what is expected of them. Parents will be encouraged to set clear, reasonable and realistic expectations of their children. This will involve being specific when providing instructions to the child, and making sure that expectations placed on the child are reasonable for a child of that age. Parents will also be encouraged to develop a ‘change plan.’ This involves responding to the child consistently whenever they meet, or fail to meet, an expectation so the child is able to easily understand the consequences of their actions. Parents will be informed about the ‘future planning’ component of this weeks individual child therapy session, as well as the two hypothetical scenarios presented to the children in this weeks child group session. Homework this week will include implementing the new discipline plan developed in today’s session as well as helping their child with their homework. Given that this is the last parent group session, parents will say farewell or can exchange contact details if they desire to stay in contact with each other.

WEEK SEVEN CBT.

- Combined Parent and Child Session (60 minutes)

Goals: For the parent and child to meet together with the therapist and discuss the progress made over the course of the program. This session will involve the therapist pointing out the progress made by both the child and the parent. The therapist will also ask the parent and child to discuss what they feel they have gained from the experience, what has improved and what they still hope to work on. The parent and child will have the opportunity to provide feedback on what they feel were the best and worst aspects of the program. The therapist will summarise the key aspects that were covered during

the program for both the child and the parent and will encourage discussion around how they will both cope with future stressful situations – i. e. What skills are they taking away from therapy that they feel they can use in the future? Changes in the child's problematic behaviour (that was reported in week one) will be discussed and any further concerns will be addressed. A time will then be made for a follow up assessment in 12 weeks time.

Table 1. Children’s Therapy Schedule- Summary of Weekly Content.

Week	Session	Duration	Protocol
1	Combined Parent & Child Session <i>(No child group)</i>	60 mins	<u>Engagement</u> <i>Parent & Child</i> <ul style="list-style-type: none"> • Introductions and discussion of the programme • Problematic behaviour identification (trauma-related) in the child • Setting up of a reward system for child engaging in more adaptive behaviour <i>Parent alone</i> <ul style="list-style-type: none"> • Clarify that the child is the focus of the programme • Affirm importance of parent’s role • Answer any questions <i>Child alone</i> <ul style="list-style-type: none"> • The magic wand task • Answer any questions • Measuring distress: SUDS <i>Parent & Child</i> <ul style="list-style-type: none"> • Setting up a regular time for homework to be done
2	Individual Session 2	60 mins	<u>Identifying feelings & Stinking Thinking</u> <ul style="list-style-type: none"> • Feelings: What are they, how to identify them, how they link to thoughts • Introduce child to ‘stinking thinking’, how to identify it • Assisting child to identify their own ‘stinking thinking’
	Child Group Session 1	60 mins	Kids to meet one another; do up posters to decorate rooms; suggest games/activities
3	Child Group Session 2	60 mins	<u>Why has this happened to me & how can I feel better?</u> <ul style="list-style-type: none"> • Establish group rules • Children share their experiences of parental separation • Children share their strategies to cope with unpleasant feelings • Unpleasant feelings – what are they and how do we recognise them • SIT training - Diaphragmatic breathing (‘calm breathing’) - Progressive muscle relaxation (‘muscle relaxing’)
	Mini-Assessment	60 mins	Child completes mini assessment with alternate therapist: Assessment measures include: RCMAS, CPSS, CDI
4	Individual Session 3	60 mins	<u>Graded Imaginal Exposure</u> <ul style="list-style-type: none"> • Review SIT • Exposure – child is assisted to tell their story, and to repeat it throughout the session • <i>Small group session</i>: Introduce discussion of stinking thinking scenarios, discuss scenario 1
	Child Group Session 3	60 mins	More on Stinking Thinking 1 & Anger Identification and Expression
5	Individual Session 4	60 mins	<u>Exposure with challenging</u> <ul style="list-style-type: none"> • Exposure – child continues to tell their story, with increasing detail • Identification of child’s own ‘stinking thinking’, with appropriate challenging • <i>Small group session</i>: Discuss Stinking Thinking scenarios 2 & 3
	Child Group Session 4	60 mins	More on Stinking Thinking 2 & Reducing Immediate Anger
6	Individual Session 5	60 mins	<u>Exposure with challenging and future planning</u> <ul style="list-style-type: none"> • Exposure – child continues to tell their story, with increasing detail • More on child’s own ‘stinking thinking’, with appropriate challenging • Planning for future stressful situations (i.e. parental conflict at handover) • <i>Small group session</i>: Discuss Stinking Thinking scenario 4, kids’ own examples, and challenging their stinking thinking
	Child Group Session 5	60 mins	More on Stinking Thinking 3 & Challenging angry thoughts and implementing more effective behaviours
7	Combined Parent & Child Session	60 mins	<u>Moving on</u> <i>Parent & Child</i> <ul style="list-style-type: none"> • Review of the problematic behaviour – how it has progressed • Parent & child share what they have learnt, what has changed and how? • What did they like and dislike? • What was useful and what was not? • Discussion about future planning <i>Parent Alone</i> <ul style="list-style-type: none"> • More elaborate review of child’s and parent’s programmes in the child’s absence. <i>Child Alone</i> <ul style="list-style-type: none"> • Further comments from child in parent’s absence (where applicable).
	Post-Treatment Assessment	60 mins	<i>Child and alternate therapist</i> Child completes assessment package with different therapist. <i>Parent Alone</i> Parent completes assessment package on own.
	3-month Follow-up Assessment	60 mins	Assessment Battery (to be administered by a different therapist)

Table 2. Parent Group Schedule- Summary of Weekly Content, Concurrent with Weeks 2-5 of Children's Therapy Program.

Week	Session	Duration	Protocol
2	Group Session 1	120 mins	<u>The impact of the conflict on my child</u> <ul style="list-style-type: none"> • Introductions • Group rules and confidentiality • The impact of the conflictual parental relationship on the child • How children react to parental separation • Summary of what the children are doing this week - Introduction to feelings identification/expression & 'stinking thinking'
3	Group Session 2	120 mins	<u>The impact of the conflict on my child & what I can do</u> <ul style="list-style-type: none"> • Watch the "Children in Focus" video – illustrates the impact of the fighting on the child • What needs to change and how I can help my child – what we will be covering over subsequent weeks • Providing stability and security • Improving my relationship with my child • Summary of what the children are doing this week - Introduction to relaxation strategies: diaphragmatic breathing and progressive muscle relaxation
4	Group Session 3	120 mins	<u>Reducing the conflict and communications skills</u> <ul style="list-style-type: none"> • Minimising the child's exposure to parental conflict • Conflict reduction and communication skills training • Self-regulation – my triggers and conflict style • The triggers and conflict style of my ex-partner • Problem solving in difficult situations • Summary of what the children are doing this week – Exposure: the purpose, the method, and how my child might respond (Small group session: More on 'Stinking Thinking' 1)
5	Group Session 4	120 mins	<u>Being an effective and positive parent</u> <ul style="list-style-type: none"> • Identifying how their role as parent has changed post-separation, and areas of difficulty • The importance of effective management of behaviour • Managing their child's behaviour positively • Watch the "Positive Parenting" video illustrating how to implement the principles • Summary of what the children are doing this week – Further exposure with challenging (Small group session: More on 'Stinking Thinking' 2)
6	Group Session 5	120 mins	<u>Making co-parenting work better</u> <ul style="list-style-type: none"> • Review Positive Parenting principles • How to respond to undesirable behaviour; how to set negative consequences for children (when positive reinforcement isn't effective) • Identify the strengths of each parent and discuss how to make the most of those for the child's benefit • The importance and benefits of a parental coalition • How to break down barriers to a parental coalition • Summary of what the children are doing this week – Exposure with challenging & future planning (Small group session: More on 'Stinking Thinking' 3)

The Bibliotherapy Condition.

This form of treatment was designed to be completed independently by the parents, with the assistance of the research facilitator provided only when requested. Parents were given seven weeks to read the book- 'Mum's House, Dad's House' (Ricci, 1997). Following this they attended the Brain Sciences Institute for their post treatment

assessment. This assessment was similar to the intake assessment, taking approximately one hour to complete. Parents were then contacted 12 weeks later to arrange the follow up assessment. Further description of content covered in this book is covered in the Materials section.

6.3.3. Materials

The same assessment battery was used for children taking part in either condition, at intake into the program, immediately following the completion of treatment, and at the 3 month follow-up. At each of these child assessments, the participating parent completed a CBCL on behalf of their child, as well as some general questions regarding demographic and wellness information (refer to Appendix F for a copy of this measure). Each parent was asked at intake: “How happy are you with your relationship with _____ (insert child’s name)? Please rate on a scale from 0= not at all happy and 10 = extremely happy: _____.” Available psychometric information for each measure used is given below.

Child Behaviour Checklist (CBCL; Achenbach, 1991): Completed by Parent.

The Child Behavior Checklist (CBCL; Achenbach, 1991), was designed as an instrument to be completed by a child’s caregiver, and forms the parent report version of the Achenbach System of Empirically Based Assessment (ASEBA). It is a highly respected measure that assesses a wide range of problem behaviours for children aged 6-18 years. Its 118 items allow for the caregiver to respond to each described behaviour on a Likert Scale of 0= ‘Not at all true,’ 1= ‘somewhat or sometimes true’ or 2= ‘Very true or often true.’ These items are summed to provide statistical scores on both Internalizing and Externalizing behavioural states. The Internalizing scale provides scores for three clinical syndromes- Withdrawn, Somatic Complaints and Anxious/Depressed. The Externalizing scale provides scores for two clinical syndromes, namely, Delinquent Behaviour and Aggressive Behaviour.

Achenbach and Rescorla (2001) reported the internal consistency of the empirical based scales of the CBCL as extremely good with alpha values ranging from .78 to .97. For

the DSM-IV scales, internal consistency was also very high with alphas ranging from .72 to .91. Test-retest reliability of empirically based scores was reported as excellent with a mean r of .90, this was similarly high for the DSM-IV scales with an r of .88. Convergent validity of the CBCL was established with correlations between scales scores and DSM-IV checklist scores ranging from .49 to .80 (for the empirically based scales) and .43 to .80 (for the DSM-IV scales). The CBCL also reliably discriminated between referred versus non-referred children with a rate of 85% accuracy for all problem items.

In order to carry out reliable and clinical change analyses, data was utilised from the original research used to norm the CBCL measure (Achenbach & Rescorla, 2001). Given that the norms created were dependent on the subjects gender and age (6-11 and 12-18 years), data to carry out reliable and clinical change analyses from the current study consisted of the following, all of which was sourced from the ASEBA manual (Achenbach & Rescorla, 2001).

For the Internalising subscale, test-retest reliability was previously found to be 0.91. Data representing clinical scores was obtained from clinically referred children (Females aged 6 - 11, $M = 13.4$, $SD = 9.4$; Males aged 6 - 11, $M = 14.3$, $SD = 9.6$; Males aged 12 - 18, $M = 14.5$, $SD = 9.1$). Data representing normal scores was obtained from a large-scale study of the general population, from children whose parents claimed were not currently experiencing any mental illness (Females aged 6 - 11, $M = 6$, $SD = 5$; Males aged 6 - 11, $M = 5.1$, $SD = 4.8$; Males aged 12 - 18, $M = 5.6$, $SD = 5.3$).

For the Externalising subscale, test-retest reliability was previously found to be 0.92. Data representing clinical scores was obtained from clinically referred children (Females aged 6 - 11, $M = 19.8$, $SD = 12.6$; Males aged 6 - 11, $M = 23.8$, $SD = 12$; Males aged 12 - 18, $M = 22.9$, $SD = 13$). Data representing normal scores was obtained from a large-scale study of the general population, from children whose parents claimed were not currently experiencing any mental illness (Females aged 6 - 11, $M = 6.1$, $SD = 5.6$; Males aged 6 - 11, $M = 6.6$, $SD = 6$; Males aged 12 - 18, $M = 7.5$, $SD = 7.5$).

The Standard Deviation used to calculate reliable change was always the Standard Deviation of the clinical sample, and this changed depending on the age and gender of

the individual participant. It should be noted that Mean scores for females aged 12 - 18 are not presented here, given that none of the sample from the current study fell in to this age/gender bracket.

Anxiety: The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978)

The RCMAS was designed as a clinical measure of perceived anxiety in children. It is a revision of Casteneda, McCandless and Palermo's (1956) Children's Manifest Anxiety Scale (CMAS). The RCMAS has the benefit of allowing for the assessment and evaluation of psychometric standards. It has been widely used in research and as an aid in diagnosis and treatment. This measure consists of 28 items related to specific feelings of anxiety, as well as 9 items that assess the child's tendency to lie, or to answer in a more socially desirable way.

The 28 items relating to anxiety form 3 sub scales- a physiology factor, which gives an indication of the degree of physiological symptoms experienced due to anxiety, a worry/oversensitivity factor, which indicates the child's tendency to internalise their experiences and withdraw if feeling overwhelmed, and a concentration anxiety factor which indicates the tendency to feel inadequate, unable to meet expectations and unable to concentrate. Each of the items is scored one point for a yes answer and zero points for no. A total score in excess of 19 for the 27 anxiety items, is thought to reflect a clinically significant level of anxiety (Stallard, Velleman, Langsford, & Baldwin, 2001).

Reliability of the RCMAS is very good. In a sample of 97 kindergarten children, the coefficient alpha was found to be high ($\alpha = 0.83$; Reynolds & Richmond, 1978). Test-retest reliability was good at .60 and .88 after one week and 5 weeks respectively and this was significant ($p < .01$; Wisniewski, Jack, Mulick, Genshaft & Coury, 1987). Convergent validity has been shown with the STAIC trait anxiety scale ($r = .85, p < .05$; Reynolds, 1980), however while the RCMAS can distinguish between those with a diagnosable problem and those without one, it was shown that it cannot distinguish between those with ADHD and those with anxiety problems (Muris, et. al., 2002). It

therefore is not recommend as a diagnostic tool but is an ideal research tool for assessing levels of anxiety in children.

In order to carry out reliable and clinical change analyses of RCMAS data in the current study, data representing scores of a normal population on the RCMAS were obtained from past research by Turgeon and colleagues (2003). The Mean used to represent the normal sample was 10.63 ($SD = 9.65$). Data representing a clinical sample from children with PTSD symptoms following single-incident traumas was obtained from research by Smith and colleagues (2007). The clinical mean used was 19.8 ($SD = 5.6$). The test-retest reliability coefficient used for reliable and clinical change analyses was taken from the Turgeon and colleagues (2003) study, which found an alpha coefficient of 0.67 over a six month period.

Depression: Children's Depression Inventory, CDI (Kovacs, 1981, 1985, 1992)

The Children's Depression Inventory (CDI) was developed as a self report measure appropriate for use by children aged 6 to 17. It assesses cognitive, behavioural and affective indicators of depression, and can be broken down in to 5 forms of depression symptoms: Interpersonal Difficulties, Negative Mood, Ineffectiveness, Anhedonia and Negative Mood. A set of three possible statements is provided for each item, to which the child can select the statement that best describes them during the past 2 weeks. Statement responses are scored as 0, 1 or 2 depending on the severity of that particular item, with higher scores indicating higher symptom severity.

Research examining the psychometric properties of the CDI has yielded results that indicate it should be used with some caution in a clinical or research setting (Saylor, Finch, Spirito, & Bennett, 1984). Internal consistency has been reported as good with an alpha coefficient of .94 for a normal sample of children, and .80 for a psychiatric sample (Saylor, Finch, Spirito, & Bennett, 1984). However, while test-retest reliability was good at .87 in the psychiatric sample, it was only .38 in the normal sample. This was still significant. Split half analyses yielded good results with values of .61 (odd/even numbered items) and .73 (first half/second half item split) for the normal sample of

children and .74 (odd/even numbered items) and .57 (first half/second half item split) for the psychiatric sample, each of which were highly significant ($p < .0001$).

Validity data for the CDI has produced mixed results. For example, while the CDI could discriminate between a normal sample of children and those with emotional distress, there was no relationship found between the CDI scores and the depressed or non-depressed scores on the Peer Nomination Inventory of Depression (PNID; Lefkowitz & Tesiny, 1980), when one would expect them to be highly related to one another. This highlights that the CDI should not be used as a stand alone diagnostic tool for depression, but rather, is an excellent way to examine levels of depressive type symptoms in children.

In order to carry out reliable and clinical change analyses of CDI data in the current study, data representing both normal and clinical samples was obtained from a study by Saylor, Finch, Spirito and Bennett (1984). The Mean of the clinical sample was 17 ($SD = 6.1$), and the Mean of the normal sample was 4.72 ($SD = 2.39$). The total CDI symptom score test-retest value used to run analyses was 0.87.

PTSD Symptoms: Children's PTSD Symptom Scale-Revised (Self-Scored) – CPSS (Foa et al 2001).

The Children's PTSD Symptom Scale (CPSS, Foa et. al., 2001) was designed to allow for the diagnosis of PTSD and to provide a measure of the severity of DSM-IV PTSD symptoms. The instrument consists of 17 items pertaining to each of the DSM-IV PTSD diagnostic criteria, providing a symptom severity score for each. Each item is rated on a 4 point Likert scale (0 = none or only at one time, 1 = Once a week or less/once in a while, 2 = 2 to 4 times a week/half the time, 3 = five times per week/almost always). There are also 7 items requiring a 'yes/no' response to indicate the areas of the child's life (relationships, school work, hobbies etc) that are affected by the symptoms reported. The 17 items form 3 sub scales, namely, 'Re-experiencing', 'Avoidance' and 'Arousal.'

Internal consistency of the CPSS was very good with alpha coefficients of .89, .91 and .90 for the 're-experiencing', 'avoidance', and 'arousal' sub scales respectively.

Test-retest reliability was good with correlations of .85, .63, and .76 respectively, and a correlation of .84 for the total symptom score (Foa, Johnson, Feeny & Treadwell, 2001). Convergent validity was demonstrated with CPSS scores correlating strongly with scores on the CPTSD-RI (.80, $p < .001$) and as expected correlations with measures of anxiety and depression were much lower than those found with the CPTSD-RI (Foa, Johnson, Feeny & Treadwell, 2001). The CPSS has demonstrated considerable strength and is a useful measure for both the diagnosis of PTSD and the assessment of PTSD symptom severity.

In order to carry out reliable and clinical change analyses of the CPSS in the current study, data representing both normal and clinical samples was obtained from Foa and colleagues (2001) paper on the CPSS's psychometric properties. The Mean of the clinical sample (those scoring high on PTSD symptoms) was 19.1 ($SD = 7.1$), and the Mean of the normal sample (those scoring low PTSD symptoms) was 5.8 ($SD = 6.8$). The total symptom score test-retest value used to run analyses was 0.84.

Perceptions of Conflict: Children's Perception of Interparental Conflict Scale (CPICS; Grych & Fincham, 1992)

The Children's Perception of Interparental Conflict scale (CPIC) assesses seven facets of interparental conflict, which can be grouped to form three higher order scales- 1. Conflict Properties (Frequency, Intensity and Resolution) 2. Threat (Perceived Threat and Coping Efficacy) 3. Self Blame (Content and Self Blame). It is a self-report measure consisting of 40 statements to which the child could response with `_true`, `_sort of true`, or `_false`.

Higher scores on the `_Conflict Properties` scale indicated higher frequency of conflict, high intensity of conflict and a lower likelihood of conflict resolution. Higher scores on the `_Threat` scale indicated a higher feeling of threat due to conflict and a poorer ability to cope during this threat. Higher scores on the `_Self Blame` scale indicated that the content of the conflict was likely to be centred on the child and that the child holds themselves responsible for the conflict.

In a sample of children as young as eight, the CPICS Conflict Properties scale demonstrated very good alpha coefficients ranging from .89 to .90 across two samples and test-retest reliability of .70 (Grych, et. al., 1992). Validity for the Conflict Properties scale was also shown to be good with significant correlations with two other measures of marital conflict intensity and frequency (O'Leary-Porter Scale and the Conflict Tactics Scale) The Threat scale alpha coefficients across the two groups were the same at .83 with reasonable test-retest reliability of .68. Scores on the Threat scale have also been significantly correlated with children ratings of threat and negative affect after watching a video showing footage of parental conflict, indicating strong validity of the scale (Grych, et. al., 1992). Alpha coefficients for the Self Blame subscales across the two samples were high ranging from .78 to .84, with good test-retest reliability of .76. Validity of the Self Blame scale was demonstrated with a significant correlation with the degree to which a child was perceived to be at fault score obtained from a video showing footage of parental conflict ($r = .32, p < .05$).

Feeling Identification: Pictured Feelings Instrument (PFI; Shack Stone, 2004).

The PFI is a relatively new instrument that was designed to allow for assessment of the ability to identify different emotional states and the frequency such states occur, in those who have difficulty describing and/or communicating their feelings. This instrument is therefore ideal for use with children who may not have developed the vocabulary to describe their feelings in a more complex way than by using basic labels such as happy, sad, good, bad etc. Even if a child doesn't know the correct word to identify a complex emotion, they seem to have the ability to point out a particular face/scenario that illustrates their current or past state. A copy of this measure is included as Appendix G for further viewing.

The PFI consists of 26 cards each representing a different emotion. Children in the current study were first asked to identify what they would be feeling if they were the person in the picture. This was done by free choice, rather than by a multiple choice style of response. This method was chosen as it was believed that children taking part in the current research may not have the vocabulary mature enough for comprehension of all multiple choice selections. Children were also asked: How often do you feel like

that?’ Ratings for this question were on a 4 point Likert scale and the child could select a response of either 1= Hardly ever, very little, 2= Sometimes/moderately, 3= Often/Quite a lot, or 4= Most of the time/a great deal.

In an initial study of the properties of the PFI cards, test-retest reliability over a two week period was found to be high with agreement ranging from 98 - 100% for the 26 cards (Shack Stone, 2004). There is very little data available on the reliability and validity of the PFI measures for free choice labelling.

Mom’s House, Dad’s House, (Ricci, 1997).

Mom’s House, Dad’s House (Ricci, 1997), is a widely available book that aims to assist parents in helping their children through divorce and/or separation. The author, Dr. Isolina Ricci, is a family therapist and mediator, who has worked in the field of divorce and separation for over 30 years. Dr. Ricci released the first edition of this book in 1980, and following its enormous success, released a revised and updated second edition in 1997. She is now the head of the office of Family Court services for the state of California in the USA. The book has been praised by family lawyers, counsellors and mediators who work with separated families. Topics covered in the book include: managing emotions post-separation, minimising conflict and building a healthy business-like relationship with the other parent, negotiating parenting arrangements, children’s reactions to separation and how to best help them cope and building a new family life. The contents of the book are centred on the idea that if the parents cope better, then the children will too, and with less conflict, parents are better able to assist their children. The book is 381 pages in length.

6.4. Results.

The results section will be split in to four sections. The first will examine child outcome measures including those of PTSD, depression, anxiety, perception of interparental conflict, as well as internalising and externalising behavioural symptoms from intake to post-treatment assessment (6.4.1) and the second will examine these same measures from the post-treatment assessment, to the follow-up assessment three months later

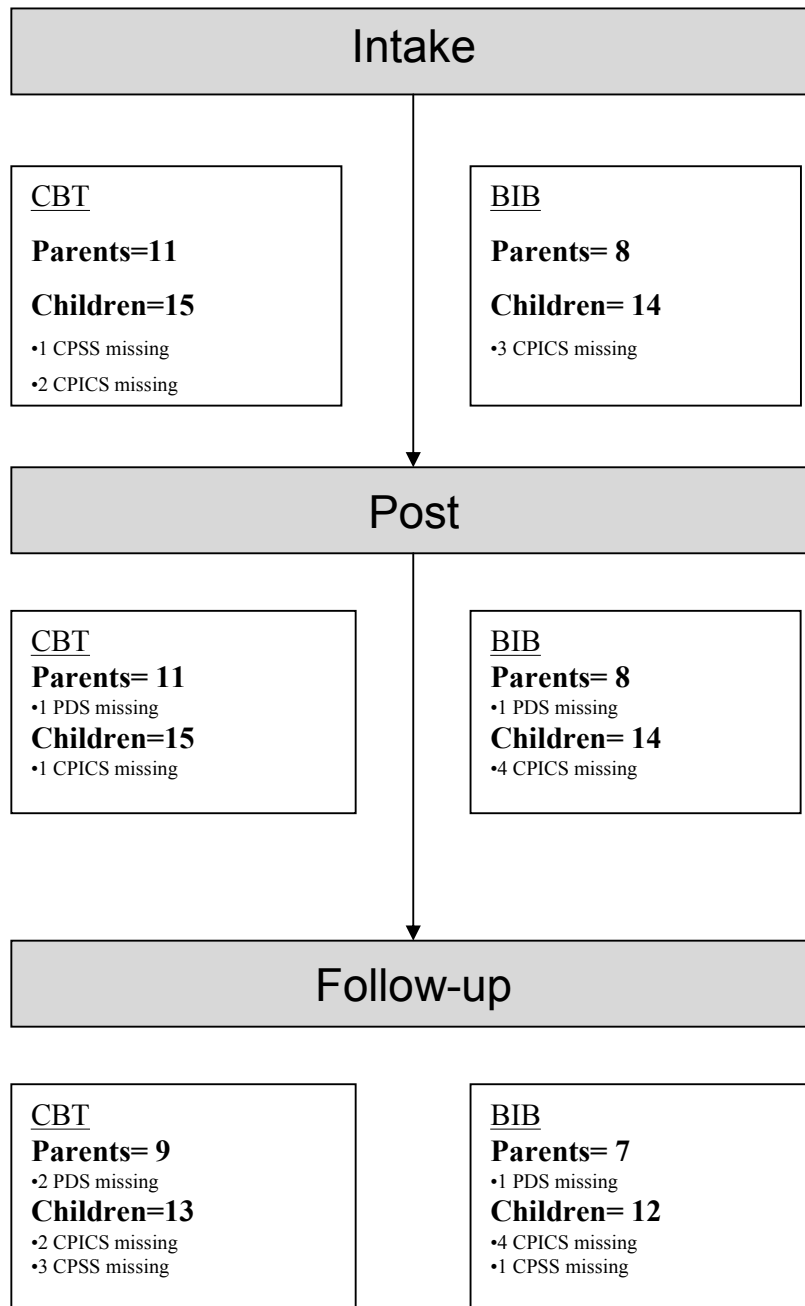
(6.4.2). The third section (6.4.3.) will examine the relationship between parental perceptions of happiness with their relationship with their child, and child outcome measures. The fourth section (6.4.4) will then examine PFI data findings related to the children's ability to correctly identify emotions. In addition, mean scores of children's reported frequency of experiencing the *_sad/depressed'* emotion depicted in card #1 and the *_happy/content'* emotion depicted in card # 2 of the PFI will be compared between treatment groups and across the three assessment time points.

While descriptive data on all subscales of each measure will be presented, analyses examining changes in symptomatology over time and between group differences will only be carried out on total scale scores, given that it is these total scores that are most relevant to the study hypotheses, and additionally this reduces the likelihood of making a Type I error.

In addition, while initial plans were to simultaneously examine results over the three time points (intake, post treatment and three-month follow up assessments), attrition rates and missing data severely reduced the number of participants at each time point in the ANOVA. In order to obtain the most accurate results, it was deemed most appropriate to first examine changes from intake to post assessments, and then separately examine changes in scores from post to follow up assessments. To test for changes between groups over these time points, repeated measures ANOVA's were carried out. Then both reliable and clinical change was examined across the main outcome measures, followed by Chi-square analyses.

Missing Data.

Total participant numbers at each time point for each condition, indicating measures that were not completed, are shown in Figure 4.



Note _BIB' = Bibliotherapy condition.

Figure 4. Participant Numbers throughout the Program, with missing data indicated.

As indicated in Figure 4, at several time points, a number of children failed to complete the CPICS. This was often due to the child being unwilling to discuss parental conflict or simply denying that they had ever witnessed past conflict (even though the research team had confirmed with both the child and the parent that past exposure to parental conflict had in fact occurred). The CPICS is rather long and many children expressed that questions were repetitive and boring. It was frequently reported by therapists that

they struggled immensely to get the child to complete this measure. For these reasons, we will reconsider our use of this instrument in future research.

Some difficulties were also experienced when trying to obtain answers to CPSS questions. For example, when asked to speak about the most upsetting event related to her parents fighting, one young girl, aged 5, said that she had no memory of her parents fighting as she had been very young when they separated. The fear reactions that led to her taking part in the program were more related to her witnessing the distress of one parent following a private conflict with her other parent and the associated upheavals surrounding the separation. Also, some children who we could assume were trying to avoid discussion of upsetting memories would suddenly deny remembering any form of severe conflict and would maintain their defiance even when the therapist prompted discussion of conflicts the child themselves had previously spoken of.

In several instances a single question was overlooked by a participant. Missing data was replaced with the mean of the subscale score for that individual. For the CBCL, only 38 data points were mean substituted out of a total of 984 possible data points. This indicated that only 0.039% of CBCL data was missing. Of all other measures combined, there were only 110 mean substituted items of a total of an estimated 122, 000 possible total data points. This equates to a percentage so small it could be considered negligible.

Therapist adherence to treatment.

Video footage taken of therapy sessions was rated for therapist treatment adherence by two independent judges who were blind to treatment outcomes. The Cognitive Therapy Scale (CTS; Young & Beck, 1980) was used to rate each session. Results revealed excellent therapist compliance with an overall whole of therapy average Intra-Class Correlation of 0.79 (95% confidence interval of 0.35 - 0.95)

6.4.1. Child Outcome Measures: Intake to Post.

Descriptive statistics indicating the Mean's and Standard Deviations of each child measure are shown in Table 3 for the CPSS, RCMAS, CDI and CPICS, and in Table 4

for the CBCL, for the intake and post treatment assessments. A 2 x 2 repeated measures ANOVA was carried out to test the hypothesis that children participating in the therapy condition would show significantly better improvement in symptoms of PTSD, anxiety, depression, internalising and externalising behaviours as well as significantly better improvement in ratings of interparental conflict, than children participating in the Bibliotherapy condition from intake to post treatment assessments.

As indicated in Table 3, the therapy condition was significantly better than the Bibliotherapy condition, in improving child symptoms of PTSD, overall daily functioning and anxiety from intake to post treatment assessments. These findings are also displayed in Figures 5, 6 and 7.

Table 3 indicates that neither condition was significantly better at ameliorating symptoms of Depression or ratings of Interparental Conflict. Table 4 indicates that neither condition was significantly better at ameliorating CBCL internalising, externalising or total scores. Of the measures that did not show significant differences between groups, symptoms were shown to significantly improve over time irrespective of condition- except in the case of the CBCL externalising subscale, which showed almost no change in scores over time for either group.

Figure's 5, 6 and 7 show the changes in mean scores for both conditions across time, for the CPSS total symptom score, CPSS daily functioning score and RCMAS total anxiety score, respectively. As can be seen in each figure, there is a consistent trend for symptoms to drop much lower in the therapy group post treatment, than in the Bibliotherapy group.

Table 3. Mean Scores, Standard Deviations, and Repeated Measures ANOVA results examining the interaction of Condition and Time at Intake and Post Treatment assessments, on measures of PTSD, Anxiety, Depression and Perception of Interparental Conflict.

Measure	CBT		Bibliotherapy		Condition F	Time F	Condition vs. Time F
	Intake	Post	Intake	Post			
CPSS							
Reexperiencing	4.40 (3.38)	1.20 (1.32)	3.79 (3.75)	4.21 (4.14)			
Avoidance	5.27 (4.06)	0.93 (1.39)	5.64 (6.18)	4.21 (4.56)			
Arousal	5.33 (3.74)	2.87 (2.56)	4.57 (4.55)	3.93 (2.90)			
Daily Functioning	2.07 (1.71)	0.47 (1.06)	2.00 (1.84)	1.64 (1.60)	0.82	17.16***	7.09*
Symptom Score	15.00 (9.70)	5.00 (3.78)	14.00 (13.60)	12.36 (10.94)	0.96	9.91**	5.11*
CPSS N	n = 15		n = 14				
RCMAS							
Physiological	5.33 (2.09)	2.93 (1.62)	4.57 (2.06)	3.78 (2.39)			
Worry/oversensitivity	5.47 (2.42)	1.47 (1.19)	4.86 (3.07)	3.14 (3.90)			
Concentration Anxiety	3.05 (1.58)	1.20 (1.42)	3.36 (2.20)	2.50 (2.17)			
Total RCMAS Score	13.85 (5.38)	5.60 (3.18)	12.79 (6.58)	9.43 (7.57)	0.51	35.15*****	6.23*
Lie 1	4.53 (1.60)	3.40 (2.69)	2.28 (2.23)	1.57 (1.87)			
Lie 2	0.93 (0.96)	.73 (.88)	.64 (.74)	.21 (.42)			
RCMAS N	n = 15		n = 14				
CDI							
Total CDI Score	10 (6.79)	5.93 (5.61)	11.21 (7.40)	8.24 (5.95)	0.72	8.59**	0.21
CDI N	n = 15		n = 14				
CPICS							
Frequency	7.58 (2.78)	4.68 (2.65)	7.50 (3.92)	6.90 (4.23)	0.63	9.62**	4.15
Intensity	10.08 (2.11)	7.08 (4.03)	11.20 (2.90)	9.90 (3.48)	2.87	8.54**	1.33
Resolution	8.58 (2.97)	5.92 (3.92)	9.80 (2.10)	8.82 (3.95)	2.70	7.07*	1.51
Content	1.25 (1.96)	0.50 (1.17)	1.10 (2.13)	0.60 (1.07)	0.00	2.28	0.91
Threat	7.50 (3.55)	3.50 (3.74)	8.16 (3.34)	5.52 (4.39)	0.84	24.51****	1.03
Coping Efficacy	7.42 (2.71)	5.33 (3.65)	7.90 (2.77)	6.12 (3.14)	0.32	7.38*	0.04
Self	1.50 (1.88)	1.00 (1.13)	2.20 (3.05)	1.50 (2.07)	0.59	1.89	0.05
CPICS N	n = 12		n = 10				

Note: * = $p < .05$, ** = $p < .01$, *** = $p < .001$, **** = $p < .0001$, ***** = $p < .00001$

Table 4. Mean Scores, Standard Deviations, and Repeated Measures ANOVA results examining the interaction of Condition and Time at Intake and Post Treatment assessments, on CBCL measures.

Measure	CBT		Bibliotherapy		Condition F	Time F	Condition vs. Time F
	Intake	Post	Intake	Post			
CBCL							
Anxious/Depressed	9.00 (5.30)	6.80 (4.14)	7.52 (4.53)	5.03 (4.78)			
Withdrawn/Depressed	3.93 (2.94)	2.93 (1.98)	4.86 (3.59)	2.86 (2.68)			
Somatic Complaints	4.07 (3.90)	3.53 (3.36)	4.48 (4.45)	1.71 (1.81)			
INTERNALISING	17.00 (9.58)	13.27 (7.93)	16.86 (11.27)	9.61 (7.97)	0.42	9.12**	0.94
Rule Breaking Behav.	4.48 (3.35)	4.53 (3.64)	4.23 (2.22)	3.68 (3.82)			
Aggressive Behav.	13.07 (8.43)	9.80 (4.71)	12.75 (5.42)	10.51 (8.46)			
EXTERNALISING	17.55 (11.20)	14.33 (6.68)	16.99 (7.14)	14.19 (11.76)	0.01	3.19	0.01
Social Problems	5.33 (3.83)	3.93 (3.13)	5.51 (2.54)	4.30 (3.80)			
Thought Problems	3.40 (2.97)	2.98 (3.56)	3.50 (3.20)	2.28 (2.67)			
Attention Problems	6.60 (5.83)	5.53 (4.66)	7.34 (4.39)	6.00 (4.15)			
Other Problems	6.13 (4.56)	5.63 (3.90)	7.28 (4.16)	5.27 (3.52)			
CBCL TOTAL	56.01 (30.96)	45.68 (20.51)	57.48 (24.44)	41.65 (28.62)	0.02	7.09*	0.31
CBCL N	n = 15		n = 14				

Note: * = $p < .05$, ** = $p < .01$, CBCL = Child Behavior Checklist.

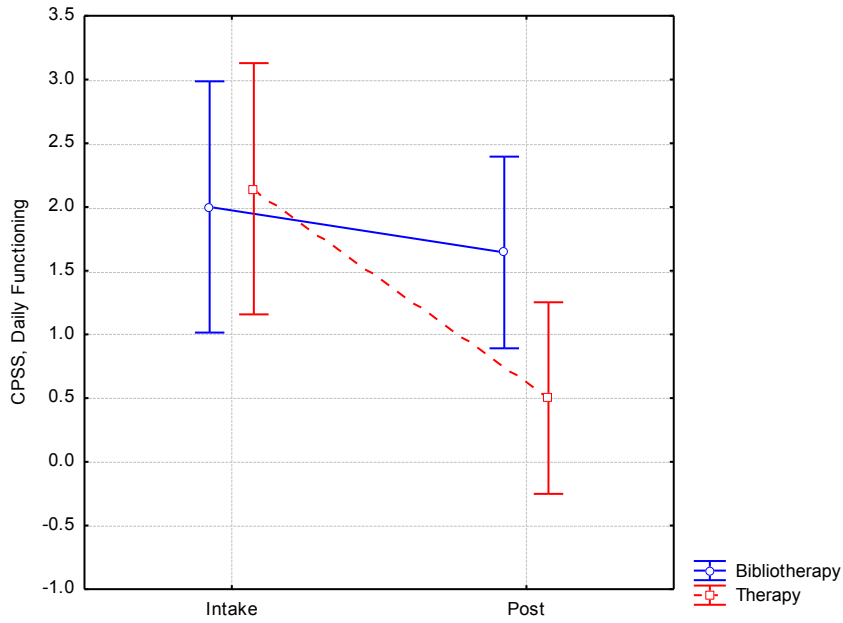


Figure 5. Diagram showing the significant interaction of CPSS daily functioning scores at intake and post assessments for both conditions. (Note that a lessening in Daily Functioning scores indicates that the rated trauma had less impact on Daily Functioning, and is therefore a desirable result).

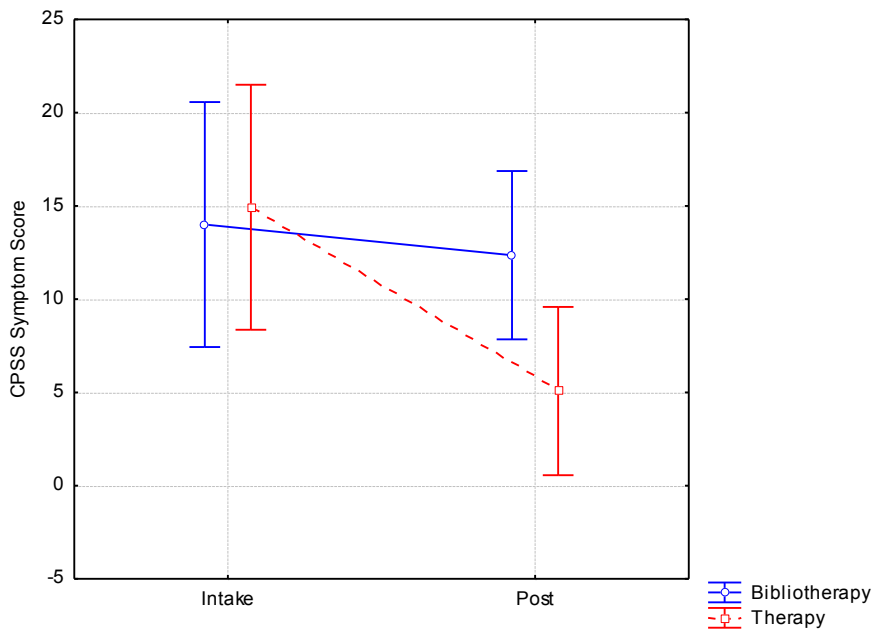


Figure 6. Diagram showing the significant interaction of CPSS total PTSD symptom scores at intake and post assessments for both conditions.

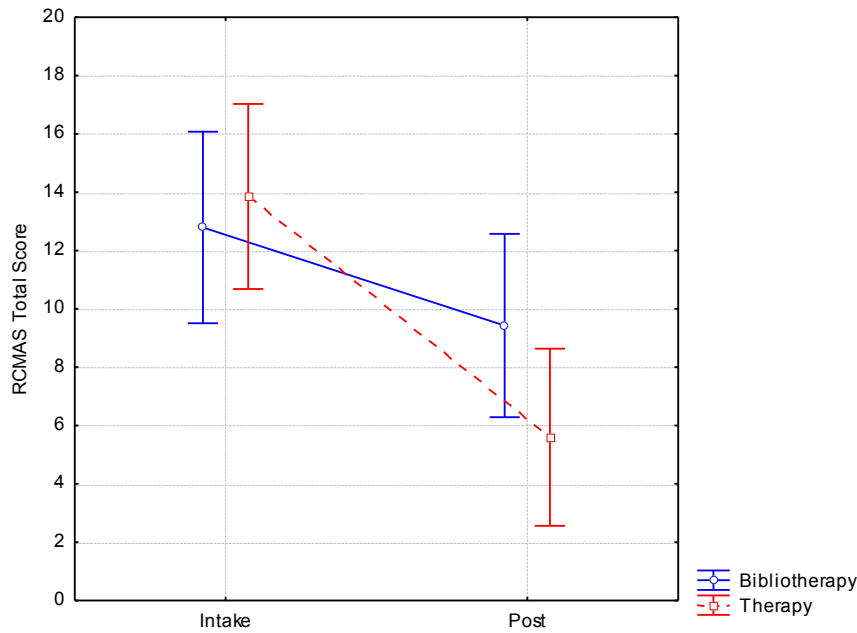


Figure 7. Diagram showing the significant interaction of RCMAS total anxiety scores at intake and post assessments for both conditions.

Reliable and Clinical Change: Intake to Post.

In clinical research it is important to consider whether changes in symptom scores indicate a *clinically meaningful* change. To further explain, if a score of 15 and above was considered ‘clinical’ and a participant at time 1 scored 15 and at time 2 scored 14, it would appear that this person had moved in to the ‘normal’ range of scores by time 2. However, this change in score may not actually be a clinically significant change, given that other factors such as measurement error might in fact be responsible for the difference of one point between measurement at time 1 and time 2. By examining clinically meaningful change, we determine how many points a score needs to change by in order to be clinically significant- that is, in order to for a person to have actually changed an amount that cannot be better explained by measurement error.

Analyses were carried out in order to examine the exact number of children in each condition who showed clinically significant improvement in PTSD symptoms, Depression, Anxiety,

Internalising behaviour, and Externalising behaviour. Participants were considered to have significantly and reliably improved if their scores had moved at least 1.96 Standard Deviations towards the normal range of scores, by the post assessment.

A 2 x 2 chi-squared analysis was carried out in order to examine whether one condition had a significantly higher proportion of children who significantly improved in symptoms than the other. When the N value of any cell was less than 5, the chi-squared value is reported but the *p* value reported is that of Fisher's exact test- a test more appropriate when low N is used. Table 5 indicates the proportion of participants in each condition who from Intake to Post assessments reliably improved, indicated no reliable change, or who reliably worsened, for each main outcome measure.

Table 5. Proportion of participants in each condition who from intake to post assessments reliably improved, indicated no reliable change, or who reliably worsened, for each main outcome measure.

Measure	CBT			Bibliotherapy		
	Reliably Improved	No Reliable Change	Reliably Worsened	Reliably Improved	No Reliable Change	Reliably Worsened
PTSD symptoms (CPSS)	7	7	0	2	10	2
Depression (CDI)	2	9	0	4	6	0
Anxiety (RCMAS)	1	14	0	0	14	0
Internalising (CBCL)	6	9	0	5	8	1
Externalising (CBCL)	3	11	1	3	9	2

*Numbers in this table represent all participants-not excluding those who at intake scored in the normal range.

Of the 14 children in each condition who completed the CPSS, 12 in the CBT condition and 9 in the Bibliotherapy condition indicated clinically significant levels of PTSD symptoms. While exactly half of the 14 children in the CBT condition indicated clinically reliable improvement, of the Bibliotherapy children, only two reliably clinically improved. Ten of the Bibliotherapy children indicated no reliable change, and a further two reliably worsened. A 3 x 2 chi-square test was carried out including only those children who were considered to have clinically significant levels of PTSD symptoms at intake, in order to ascertain whether children of the

CBT condition were significantly more likely to clinically improve by the post assessment. Results indicated that the CBT children were in fact significantly more likely to reliably clinically improve in terms of PTSD symptoms (Chi-square (2, 28) = 5.31, $p < .04$).

Not all children entering the program at intake indicated clinically significant levels of depression. For example, in the CBT group, 11 of the 15 children indicated clinically significant levels of depression, with 10 out of 14 children in the Bibliotherapy condition reaching clinical levels. A one-tailed 2 x 2 chi-square test was carried out only including those who had significant levels of depressive symptoms at intake. Results indicated that in contrast to expectations, the CBT program did not yield significantly more cases of clinical improvement in depressive symptoms than the Bibliotherapy condition (Fishers Exact (1,21) = 0.13, $p = 0.27$).

At intake, five of the 15 CBT participants, and five of the 14 Bibliotherapy participants had RCMAS scores in the clinical range. Only one participant in the CBT group indicated a clinically significant improvement in anxiety symptoms. No participant of the Bibliotherapy condition indicated a clinically significant change in anxiety score. A 2 x 2 chi-square test was carried out including only those with clinical levels of anxiety at intake. Results indicated that neither condition was more likely than the other to produce clinically significant improvement in anxiety symptoms (Fishers Exact (1, 10) = 0.50, $p = 0.14$).

Intake CBCL assessments indicated that of the 14 Bibliotherapy and 15 CBT participants, 11 from each group scored in the clinical range of the CBCL internalising subscale. Table 5 indicates that of the Bibliotherapy participants, 5 reliably improved, 5 indicated no reliable change, and one reliably worsened from intake to post assessments. Of the CBT participants, six reliably improved and 5 indicated no reliable change in scores from intake to post assessments. A 3 x 2 Chi-square test was carried out including only those who had clinically significant Internalising scores at intake in to the program. Results revealed that no condition was significantly more likely than the other to produce a significant improvement in Internalising symptoms (Chi-square (2, 22) = 1.09, $p = .29$).

Intake CBCL externalising scores indicated that each condition yielded three reliable improvements, with the CBT group having 11 participants with no reliable change in scores

and one reliable worsening of externalising symptoms, and with the Bibliotherapy group having nine participants with no reliable change and two cases of symptoms reliably worsening. Given that in one case, a participant who at intake scored in the normal range, actually reliably worsened to the extent that they scored in the clinical range at post treatment, all cases (including those who initially scored as normal) were included in the Chi-square analyses. In the above mentioned cases, only those with clinical scores at intake were examined since there were no incidences of any participant reliably worsening, who wasn't already clinical at intake. Results indicated that no one condition was significantly more likely to result in reliable change of Externalising symptoms from intake to post treatment assessment (Chi-square (2, 29) = .50, $p = .39$).

6.4.2. Child Outcome Measures: Post to Follow Up.

Descriptive statistics indicating the Mean's and Standard Deviations of each child measure are shown in Table 6 for the CPSS, RCMAS, CDI and CPICS, and in Table 7 for the CBCL, for the post treatment and follow-up assessments. A 2 x 2 repeated measures ANOVA was carried out to test the hypothesis that children participating in the therapy condition would show significantly better long-term improvement in symptoms of PTSD, anxiety, depression, internalising behaviour and externalising behaviour as well as significantly better improvement in ratings of interparental conflict, than children participating in the Bibliotherapy condition.

Table 6 indicates that there was a significant interaction of time and condition on PTSD symptom scores. Upon closer inspection (refer to Figure 8) it was revealed that this interaction went in the opposite direction than was predicted. Those children taking part in the CBT program had a tendency for PTSD symptoms to significantly *worsen* from post treatment to the three month follow-up. In addition, upon investigation of the significant interaction of 'parental conflict intensity' (CPICS; refer to Figure 9) it was found that children taking part in the CBT program had a tendency to report significantly *higher* intensity of parental conflict than their Bibliotherapy counterparts, in the three months since treatment ceased. Further discussion and analysis of this data is carried out in the following section on page 138, and again in section 6.5.1.

As predicted, children taking part in the CBT program showed a greater improvement in internalising symptoms than children from the Bibliotherapy group (displayed in Figure 10). No other significant interactions were observed on other measures of anxiety, depression or interparental conflict, indicating that neither condition was better or worse than the other at treating these symptoms. It should be noted however, that parental conflict frequency (as reported by the children) and overall CBCL total scores, showed a significant decline from post treatment to the three month follow up assessment, regardless of condition. This indicated that both conditions did in fact result in a significant benefit to the children involved- that is, children in both conditions indicated a lessening of both their own maladaptive behaviours overall, as well as a reduction in interparental conflict exposure.

Table 6. Mean Scores, Standard Deviations, and Repeated Measures ANOVA results examining the interaction of Condition and Time at Post and Follow-Up assessments, on measures of PTSD, Anxiety, Depression and Perception of Interparental Conflict.

Measure	CBT		Bibliotherapy		Condition F	Time F	Condition vs. Time F
	Post	Follow-Up	Post	Follow-Up			
CPSS							
Reexperiencing	1.10 (0.99)	2.50 (2.46)	4.73 (4.34)	3.36 (2.84)			
Avoidance	0.60 (1.07)	4.30 (5.40)	5.00 (4.77)	4.82 (5.27)			
Arousal	3.10 (2.28)	4.60 (4.57)	4.45 (2.98)	2.54 (1.86)			
Daily Functioning	0.60 (1.26)	0.60 (1.58)	2.00 (1.61)	1.45 (1.63)	3.60	0.76	0.76
Symptom Score	4.80 (3.64)	11.40 (11.95)	14.18 (11.31)	10.73 (8.51)	1.58	0.48	4.95*
	n = 10		n = 11				
RCMAS							
Physiological	3.00 (1.73)	3.54 (2.73)	3.67 (1.72)	3.42 (2.11)			
Worry/oversensitivity	1.46 (1.26)	2.86 (3.80)	2.92 (3.73)	2.42 (2.19)			
Concentration Anxiety	1.31 (1.49)	1.92 (2.29)	2.58 (2.19)	2.50 (2.07)			
Total RCMAS Score	5.77 (3.34)	8.32 (8.17)	9.17 (6.73)	8.33 (5.21)	0.65	0.48	1.85
Lie 1	3.46 (2.63)	4.00 (2.64)	1.42 (1.88)	1.75 (2.53)			
Lie 2	0.85 (0.90)	1.31 (1.25)	0.17 (0.39)	0.25 (0.62)			
	n = 13		n = 12				
CDI							
Total CDI Score	6.38 (5.87)	7.00 (6.27)	9.12 (5.87)	6.67 (4.23)	0.35	0.87	2.42
	n = 13		n = 12				
CPICS							
Frequency	4.74 (3.04)	7.45 (3.42)	7.25 (4.71)	7.75 (3.65)	0.78	6.37*	3.01
Intensity	6.45 (3.80)	8.45 (4.16)	10.87 (3.14)	9.62 (3.20)	3.19	0.30	5.71*
Resolution	5.54 (3.96)	6.91 (3.67)	8.52 (4.42)	8.62 (4.37)	1.71	1.53	1.14
Content	0.64 (1.29)	1.45 (2.54)	0.75 (1.16)	0.37 (0.74)	0.62	0.22	1.57
Threat	2.84 (2.70)	4.80 (3.91)	6.15 (4.46)	4.35 (3.20)	1.26	0.00	3.09
Coping Efficacy	5.27 (3.82)	5.18 (3.37)	6.77 (2.91)	6.25 (1.49)	0.99	0.20	0.10
Self Blame	(1.09)	1.91 (2.62)	1.87 (2.17)	1.62 (1.60)	0.15	0.39	1.22
	n = 11		n = 8				

Note: * = $p < .05$

Table 7. Mean Scores, Standard Deviations, and Repeated Measures ANOVA results examining the interaction of Condition and Time at Post and Follow-Up assessments, on CBCL measures.

Measure	CBT		Bibliotherapy		Condition F	Time F	Condition vs. Time F
	Post	Follow-up	Post	Follow-up			
CBCL							
Anxious/Depressed	6.69 (4.46)	4.77 (3.54)	5.64 (5.06)	5.54 (5.05)			
Withdrawn/Depressed	2.92 (2.10)	1.61 (1.66)	2.91 (2.74)	3.82 (2.96)			
Somatic Complaints	3.77 (3.56)	2.54 (3.12)	2.09 (1.87)	1.54 (1.75)			
INTERNALISING	13.38 (8.56)	8.92 (6.97)	10.63 (8.21)	10.91 (8.65)	0.01	5.19*	6.62*
Rule Breaking Behaviour	3.77 (2.95)	2.54 (2.40)	4.23 (4.14)	3.82 (4.28)			
Aggressive Behaviour	9.61 (5.04)	8.15 (5.01)	12.36 (8.64)	12.27 (8.82)			
EXTERNALISING	13.38 (6.61)	10.69 (6.88)	16.59 (12.23)	16.09 (12.27)	1.27	2.31	1.09
Social Problems	3.61 (3.01)	3.85 (3.02)	5.18 (3.84)	5.45 (4.06)			
Thought Problems	2.20 (2.90)	1.77 (1.92)	2.27 (2.90)	2.73 (2.61)			
Attention Problems	4.85 (4.47)	4.38 (4.35)	6.45 (4.48)	5.27 (4.63)			
Other Problems	5.42 (4.15)	4.08 (4.13)	5.70 (3.83)	4.56 (3.19)			
CBCL TOTAL	42.86 (19.95)	33.69 (20.27)	46.84 (29.92)	45.01 (30.94)	0.58	4.37*	1.95
CBCL N	n = 13		n = 11				

Note: * = $p < .05$, CBCL = Child Behavior Checklist.

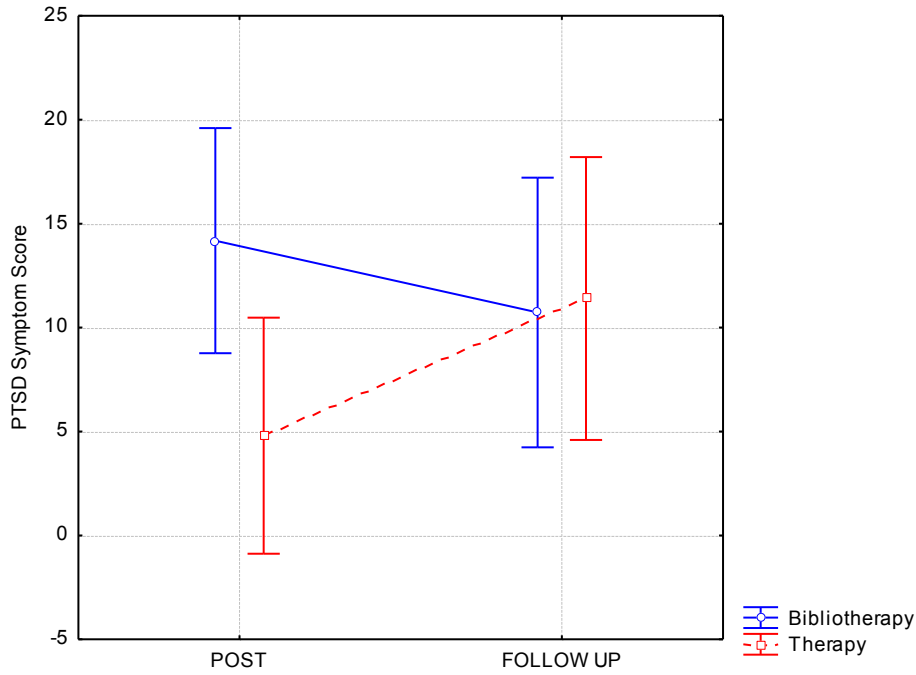


Figure 8. Diagram showing the significant interaction of CPSS PTSD symptom scores at post treatment and follow-up assessments for both conditions.

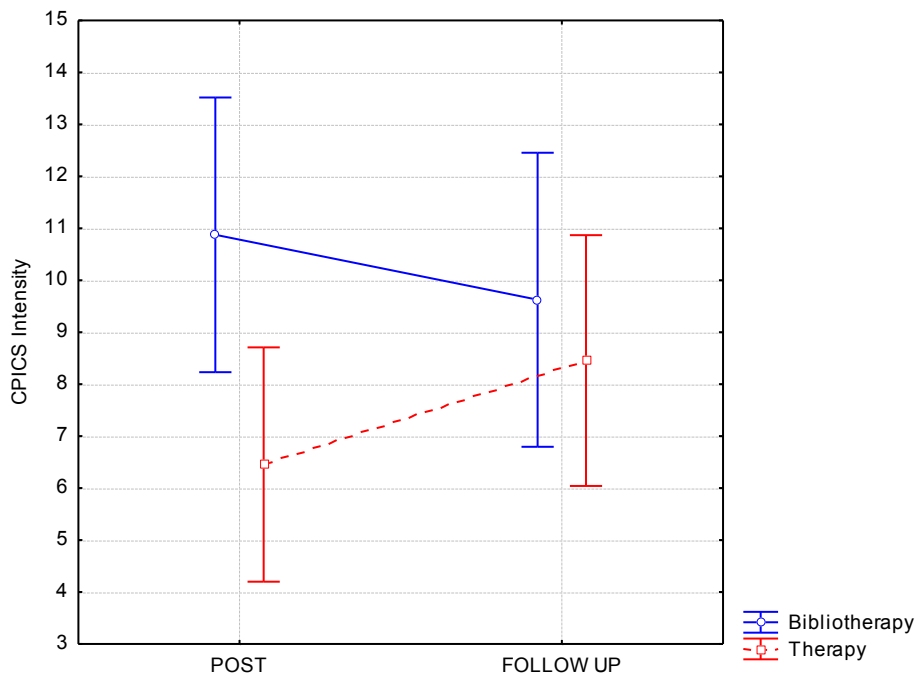


Figure 9. Diagram showing the significant interaction of CPICS parental conflict intensity scores at post treatment and follow-up assessments for both conditions.

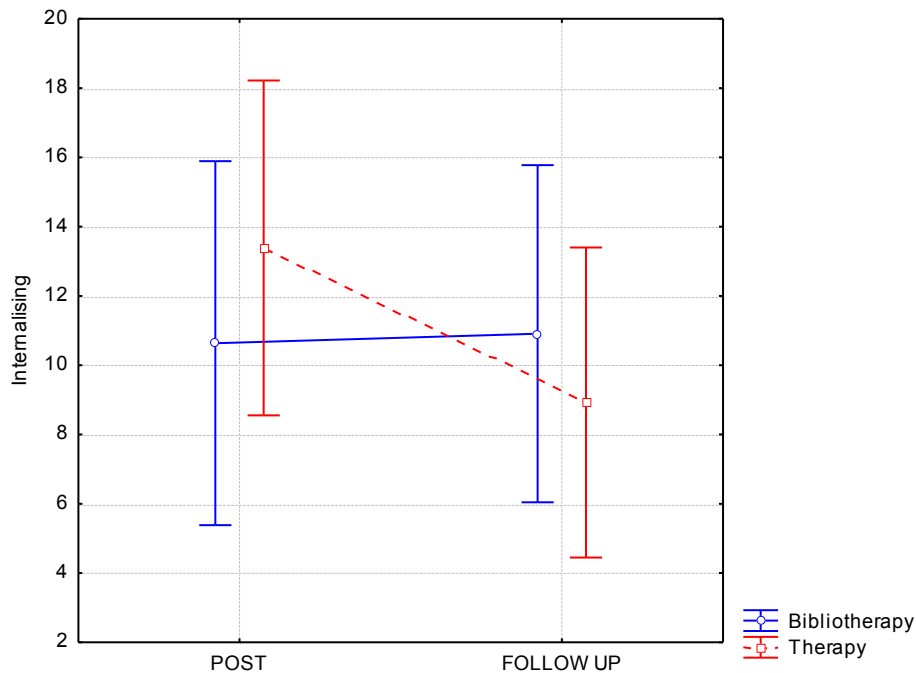


Figure 10. Diagram showing the significant interaction of CBCL Internalising scores at post treatment and follow-up assessments for both conditions.

Re-analysis of PTSD and CPICS intensity data excluding cases who reported a recent incident of parental conflict.

The significant worsening of PTSD symptoms and interparental conflict intensity in the CBT group from post to follow-up assessment was of concern to the investigators. Upon closer inspection of the data, it was revealed that five children of the CBT condition, and two of the Bibliotherapy condition, had experienced a recent incident of high level parental conflict, only weeks before the follow-up assessment. In order to determine whether PTSD scores and CPICS intensity scores were being pushed up by these recent incidences of new trauma, Repeated Measures ANOVA's were carried out, excluding these cases. With these cases excluded, and with several data points missing due to participants dropping out at follow up, participant numbers for the analyses were extremely low. For this reason, the data presented in Table 8 should be interpreted with caution.

Table 8. Mean Scores, Standard Deviations, and Repeated Measures ANOVA results examining the interaction of Condition and Time at Post and Follow-Up assessments, on PTSD symptom scores and CPICS Interparental conflict intensity scores, with those participants reporting recent parental conflict excluded from analyses.

Measure	CBT		Bibliotherapy		Condition <i>F</i>	Time <i>F</i>	Condition vs. Time <i>F</i>
	Post	Follow-up	Post	Follow-up			
PTSD Symptoms	5.20 (5.40)	11.40 (14.57)	10.22 (7.79)	7.89 (5.97)	0.04	0.38	1.85 <i>ns</i>
	n = 5		n = 9				
CPICS Intensity	5.00 (3.35)	6.50 (4.28)	9.83 (2.93)	9.50 (3.78)	4.50	0.35	0.88 <i>ns</i>
	n = 6		n = 6				

Note: *ns* = not significant.

Table 8 indicates that PTSD scores and parental conflict intensity scores, did not change significantly from post to follow-up assessment, when only examining those children who did not report a recent parental conflict. This implies that recent conflict may be responsible for elevation in PTSD symptoms, and reports of high intensity parental conflict, that were reflected in previous analyses that included all cases. We cannot assume this relationship is causal, given that participant numbers were very low and it is possible that some other extraneous variable could explain these results. It was not possible to conduct similar analyses including only those who *did* report a recent parental conflict, as this would have reduced participant numbers to just 2 and 5 for the Bibliotherapy and CBT groups respectively.

Reliable and Clinical Change: Post treatment to Follow-up Assessment.

Analyses were carried out in order to examine the exact number of children in each condition who showed clinically significant and reliable improvement in PTSD symptoms, Depression, Anxiety, Internalising and Externalising symptoms, from post treatment to the three month follow up. As with the intake-post analyses, participants were considered to have significantly improved if their scores had moved at least 1.96 Standard Deviations towards the normal range

of scores, by the three month follow-up assessment. However, it was hypothesised that scores would remain relatively stable at the follow-up.

Chi-square analyses were carried out in order to examine whether one condition had a significantly higher proportion of children who significantly improved or significantly worsened in symptoms than the other. When the N value of any cell was less than 5, the chi-squared value is reported but the *p* value reported is that of Fisher's exact test- a test more appropriate when low N is used. Table 9 indicates the proportion of participants in each condition who reliably improved, indicated no reliable change, or who reliably worsened, for each main outcome measure, from post to follow up assessment.

Table 9. Proportion of participants in each condition who from post to three month follow-up assessment reliably improved, indicated no reliable change, or who reliably worsened, for each main outcome measure.

Measure	CBT			Bibliotherapy		
	Reliably Improved	No Reliable Change	Reliably Worsened	Reliably Improved	No Reliable Change	Reliably Worsened
PTSD (CPSS)	0	7	3	3	7	1
Depression (CDI)	0	12	1	2	9	1
Anxiety (RCMAS)	0	12	1	0	12	0
Internalising (CBCL)	2	11	0	0	10	1
Externalising (CBCL)	1	12	0	0	10	1

*Numbers in this table represent all participants-not excluding those who at intake scored in the normal range.

There were 10 children from the CBT program and 11 children from the Bibliotherapy condition who completed the CPSS at the three month follow up. As indicated in Table 8, of the CBT group, no child indicated a reliable improvement from post to follow-up, seven children showed no reliable change and three children reliably worsened. Of the Bibliotherapy group, three children reliably improved, seven children showed no reliable change and one

child reliably worsened. A 3 x 2 chi-square test revealed no significant difference between groups in terms of clinical status from post to follow up assessments (Chi-square (2, 21) = 3.96, $p = .07$). Of the seven children in the CBT group who indicated no reliable improvement, six were already in the normal range at the post assessment anyway. The other child who indicated no reliable improvement was in the clinical range at the post assessment and remained clinical at the follow-up. All three children who reliably worsened had been in the normal range at post and had declined further in to the clinical range by follow up- something that was of concern to the investigators. Upon further investigation, it was found that these three children had each experienced a new incident of high-level parental conflict in the three months since the post treatment assessment (as reported by their mothers). Of the one Bibliotherapy child who clinically worsened, no clear explanation for the worsening of PTSD symptoms was identified.

Upon examination of the RCMAS total scores from post to follow up assessments, a tendency for clinical status to remain stable was indicated. Of the Bibliotherapy group, no one child of the 12 tested indicated a change for either the better or worse. Of the CBT group, 12 children indicated no reliable change in scores and one child indicated reliable worsening of anxiety. Overall, reliable change analysis indicated that anxiety scores, for the most part, remained stable in the three months post treatment completion for both conditions. It was not possible to carry out Chi-square analyses due to low cell numbers.

Analyses of the CDI data from post to follow up assessments revealed that scores largely remained the same over time for both groups, with the exception of one child in each condition worsening, and two children in the Bibliotherapy condition reliably improving. A Chi-square test indicated no condition was significantly better at reliably improving depression scores than the other (Chi-square (2, 25) = 2.39, $p = .15$).

Analyses of CBCL Internalising subscale scores indicated that for the most part, clinical classification remained stable from post treatment to the three month follow up assessment. One participant in the Bibliotherapy condition reliably worsened, with 10 remaining stable, and in the CBT group, 2 reliably improved, with 11 participants showing no reliable change. A Chi-square analysis revealed that no condition was significantly better at *clinically* improving Internalising scores from post to follow up assessments (Chi-square (2, 24) = 2.90, $p = .12$), even though prior statistical analyses (refer to Table 7) indicated that scores overall, did

significantly change. To clarify, while total Internalising scores significantly changed, clinical classifications did not significantly change.

CBCL Externalising scores tended to remain stable from post to follow up assessments for both conditions. The CBT and Bibliotherapy groups had 12 and 10 participants, respectively, who indicated no reliable change in scores, with one participant reliably worsening in the Bibliotherapy group and one reliably improving in the CBT group. Given that the one Bibliotherapy participant who reliably worsened actually moved from a normal score at post to a clinical score at follow up, cases that at post were considered to score within the normal range, were included in Chi-square tests. Results indicated that neither condition was significantly more likely to result in reliable change of Externalising scores (Chi-square (2, 24) = 2.03, $p = .18$).

6.4.3. Parental Perception of Child Relationship Analyses.

In order to examine the hypothesis that positive parental perceptions of happiness with their relationship with their child, would be related to more positive therapy outcomes, correlations were computed. Mean score's on the question "How happy are you with your relationship with your child (scored from 1-10)," were similar for each condition (Bibliotherapy: $M = 7.86$, $SD = 1.67$; CBT: $M = 7.61$, $SD = 2.17$). Correlations were performed separately for each condition, in order to examine whether relationship quality would show a varied degree of association to outcome measures, depending on condition. Relationship happiness at intake into the program was correlated with RCMAS total score, CDI total score, PTSD total symptom score, PTSD daily functioning score, Internalising Behaviour, Externalising behaviour and CBCL total score, at intake, post and follow-up assessments. Results, delimited by condition, are displayed in Table 10. Note that given the high number of correlations performed, and the increased likelihood of a significant result occurring by chance alone, the significance level was adjusted to the more stringent level of $p < .01$. Also, note that a negative correlation indicates that as parental happiness with their relationship with their child increased, symptoms tended to be lesser in these children.

Table 10. Correlations between parental ratings of happiness with their relationship with their child, and all relevant outcome measures.

Time Point	Measure	Parental happiness with relationship with their child	
		CBT <i>N</i> = 21	Bibliotherapy <i>N</i> = 21
Intake			
	RCMAS Total	-.34	.62
	CDI Total	-.40	.40
	PTSD Symptom Score	-.15	.68
	PTSD Daily Functioning	-.08	.32
	Internalising	-.51	-.42
	Externalising	-.75	-.57
	CBCL Total Score	-.55	-.50
Post			
	RCMAS Total	.49	.62
	CDI Total	.22	.66
	PTSD Symptom Score	.09	.71
	PTSD Daily Functioning	.24	.48
	Internalising	-.01	-.41
	Externalising	-.60	-.47
	CBCL Total Score	-.19	-.46
Follow-Up			
	RCMAS Total	.12	.40
	CDI Total	-.09	.39
	PTSD Symptom Score	.01	.45
	PTSD Daily Functioning	.14	-.18
	Internalising	-.05	-.52
	Externalising	-.78	-.59
	CBCL Total Score	-.31	-.61

Note: Correlations equal to or stronger than $-.55$ or $.55$ are indicated in bold.

Table 10 indicates that there was no significant relationship between parental happiness with their relationship with their child, and any outcome measure. It should be noted however, that some relationships between variables were quite strong, but possibly didn't quite reach significance due to low participant numbers. It is still of importance to examine which variables indicated strong relationships with each other, despite, not reaching our stringent significance levels. For this reason, correlations equal to or stronger than $-.55$ or $.55$ (indicated in bold type in Table 10) will be further discussed.

Table 10 indicates that for the CBT condition, there was a consistent trend at all three assessment time points, for higher child relationship happiness to be related to lower externalising scores. That is, those children whose parents were happier with their relationship with their child at intake were less likely to report Externalising Behavioural problems, than those whose parents rated their relationship as less happy.

Correlations for the Bibliotherapy condition were far less straightforward. For example, there were moderately strong positive correlations between child relationship happiness and measures of RCMAS total score and PTSD total symptom score at intake. This indicated that at intake in to the program, higher ratings of happiness with their relationship with their child, were related to higher levels of anxiety and PTSD symptoms- a result in contradiction to hypothesis 4. Further, at the post treatment assessment, this positive relationship was observed again for measures of RCMAS total score, CDI total score and PTSD total symptom score. This indicated again, that those parents who rated their child relationship as happy were more likely to have children who rated highly on measures of anxiety, depression and PTSD symptoms at the post-treatment assessment.

By the follow-up assessment, this relationship had disappeared and instead, there was a moderate negative relationship between child relationship happiness and Externalising behaviours. This indicated, in keeping with predictions, that those children in the Bibliotherapy condition, whose parents rated their relationship with them as happier, were more likely to report fewer symptoms of externalising behaviours at follow-up.

Overall, it could be said that correlations indicate for children of the CBT condition, that a happier relationship between mother and child, was related to fewer Externalising behavioural problems at all assessments, however, this was a moderate relationship that was not quite significant at $p < .01$. For the Bibliotherapy condition, findings were not so straightforward, with some positive, and some negative relationships indicating a much less routine effect of parent-child relationship happiness on outcome. These findings will be discussed in more detail in the following Discussion section.

6.4.4. Pictured Feeling Instrument Analyses.

The PFI data was carefully scored based on whether the child correctly or incorrectly identified the feeling displayed on each card. Responses were considered correct if they appeared in the PFI manual's Appendix 2 list of synonyms of acceptable responses, or if the researcher deemed the child's response as depicting the correct feeling. All PFI data was scored by one researcher. Any response given by a child that did not appear in the PFI Appendix of accepted words, whether accepted as correct or rejected was recorded and tallied in Table 11. Readers please take note that the following Table 11 therefore does not provide *all* given responses, but provides responses we received that did not appear in the PFI manual. Also, please refer to Appendix G (PFI form 3) to see a pictorial representation of each card.

Table 11. Alternate responses to the PFI cards that were accepted or rejected, pooled across all three assessments, with frequencies indicated in brackets if response occurred more than once.

PFI card	ACCEPTED	REJECTED
1 sad or depressed	left out (2), alone, hurt	nothing
2 happy or content	excited, cheerful	ok
3 joy	delighted (3), happy, proud (since it is the same as <u>happy with myself</u>)	surprised (3), bright, crazy, clever
4 confused	curious (6), wondering (3), nervous (3), clueless (2), a bit anxious, doesn't know what to do, <u>what is that?</u> , muddled	feelings are hurt
5 blamed	sad (48), worried (2), angry (2), picked on/sad (2), not loved, not happy, bad, hated, sad/angry, bullied, put down	lonely
6 angry	frustrated	sad (2), disappointed (2), thinking hard, suspicious, like someone yelled at him, looking after someone, worried
7 rage	really cross (2), grumpy (2), annoyed, super bad, yelling out	sad for them, worried, not happy
8 trapped	lonely/alone (8), upset (7), worried (4), stuck (2), angry (2), frightened (2), stuck/sad, isolated, concerned	sad (28), weird/looks funny, cold/miserable, bad, insecure, shy, unhappy, wishing he hadn't done what he had done
9 fear	upset (2), feels like done something wrong, startled	sad (2), insane, really angry, not happy, proud
10 suspicious	curious (5), cheeky (2), cautious, evil, unsure, mischievous, annoyed	angry (10), cross (6), bored (4), worried (3), mad (2), predicting what will happen, locked in, not sad, grumpy, trying to get angry, nervous, scared, happy/sad, bothered, frustrated
11 numb	plain (5), can't think, soulless, can't have his say	sad (9), confused (3), surprised (3), worried (3), cross (2), normal (2), nervous (2), unsure, tired, sleepy, crazy, scared, ugly, upset, frightened, happy, funny, weird, casual, freaked out, shy
12 friendly	joyful, great, glad	
13 lonely	everyone thinks he's a joke, jealous	angry (3), mad, not happy, annoyed
14 very upset	crying	extremely mad
15 nervous	freaked out (2), jumpy	cold (4), crazy, lonely, agitated, sad, sweaty, emotionally cold
16 winner	excited (2), great (2), lucky, delighted, achievement	
17 loser	left out (12), upset (7), embarrassed (2), scared that parent won't like them, crap, heart broken, annoyed, not good enough	alone/lonely (6), cold
18 strong	happy (11), good (3), tough (2), energetic, healthy, encouraged	angry (10), hot/can't think, hot, cross and sad, self obsessed, loved, angry/happy/cross
19 disgust	disappointed at someone (disdain?) (2), annoyed, gross	angry (43), mad (7), frustrated (4), confused (3), ashamed/guilty, weird, itchy nose, poking tongue out, grumpy, happy, vicious, evil
20 surprised	scared (6), excited (2), frightened (2), interested	sad, worried, amused, upset, happy, proud
21 loving		
22 victim	ashamed, bothered, shy, bad, obnoxious, depressed, unhappy, bullied, teased	left out (4), alone/lonely (4), hasn't done prayers, disappointed

PFI card	ACCEPTED	REJECTED
23 aggressive	mad (7), mean (2), cross (2), evil, not happy, happy to hurt someone, trying to annoy someone, strong	sad (4), looking out for someone, unfair, not a good thing to do, has done prayers, sad for other people, spying on him, sorry, upset, ashamed, hopeful, brave, happy, disappointed, don't make me sad
24 overloaded	sore (3), crushed, worn out, pressured, forced, not happy-sore back, put down	sad (29), angry (4), bored (3), alone (3), annoyed (2), upset (2), mad, unlucky, mad and sad, left out, unhappy, happy, mad, miserable
25 exhausted	sad (34), upset (3), sick (2), feeling down, bothered, lonely/sad, weak, miserable, really unhappy	left out (7), lonely/alone (3), angry, guilty, disappointed
26 shy	nervous (4), upset	happy (8), cold (3), thankful (2), angry (2), ungrateful, surprised, lucky, need to use the toilet, cheeky, honest, showing off, forgiving, pleased, passionate, sorry

As can be seen in Table 11, there are several responses to the PFI cards that should likely be included as acceptable responses when administering this instrument. For example, children had an overwhelming tendency to perceive card 5 as portraying feeling sad, card 17 as portraying feeling left out and card 25 as feeling sad. These responses were deemed acceptable, as they were thought to reflect the underlying feeling being illustrated, even if another response might be considered more accurate. Refer to Appendix G to view each card.

There were several cards where the children frequently reported a feeling that was regarded as incorrect. For example, card 8 received the response sad 28 times, card 19 was perceived as angry 43 times and card 24 was perceived as sad 29 times, all of which were considered incorrect. Again, this was the interpretation of the researcher, and of the publisher of the PFI manual, and we accept that conclusions were subjective. It may be that children aged 5-12 do not yet have the vocabulary or the understanding of feelings to be able to correctly identify these feelings. However, given that some of the incorrect responses occurred rather frequently it would suggest that rather than the children being wrong, the card may simply be too ambiguous and may not accurately portray the intended feeling.

It should be noted that some cards received such a wide variety of responses that the validity of the card for use with children, must be questioned. For example, card 26 received responses such as happy, sorry, angry and pleased. It is difficult to imagine that the same picture was being described. Table 12 indicates the percentage of cards that were correctly identified, delimited by condition and time point. The combined figures that are shaded grey indicate

those cards which were correctly identified less than 70% of the time- a level thought to indicate poor performance.

Table 12. Percentage of Pictured Feeling's correctly identified, at Intake, Post and Follow-Up assessments, with results split by condition, and then combined across groups.

PFI #	Intake % correct			Post % correct			Follow-Up % correct		
	Therapy	Bibliotherapy	Combined	Therapy	Bibliotherapy	Combined	Therapy	Bibliotherapy	Combined
1	100	92.86	96.55	100	100	100	100	100	100
2	93.33	100	96.55	100	100	100	100	100	100
3	100	85.71	93.10	86.67	100	93.10	92.31	91.67	92
4	93.33	92.86	93.10	100	100	100	92.31	100	96
5	100	100	100	100	100	100	92.31	100	96
6	100	71.43	86.21	93.33	85.71	89.65	84.61	83.33	84
7	93.33	92.86	93.10	86.67	85.71	86.21	100	100	100
8	40	64.29	51.72	46.67	85.71	65.52	76.92	75	76
9	93.33	85.71	89.65	100	92.86	96.55	92.31	91.67	92
10	26.67	71.43	48.27	53.33	57.14	55.17	53.85	58.33	56
11	13.33	7.14	10.34	6.67	42.86	24.14	7.69	58.33	32
12	93.33	100	96.55	100	100	100	100	100	100
13	93.33	92.86	93.10	86.67	100	93.10	92.31	100	96
14	100	92.86	96.55	100	100	100	100	100	100
15	93.33	50	72.41	100	92.86	96.55	100	91.67	96
16	100	100	100	100	100	100	100	100	100
17	93.33	78.57	86.21	86.67	100	93.10	100	83.33	92
18	46.67	71.43	58.62	93.33	71.43	82.76	76.92	91.67	84
19	100	21.43	10.34	13.33	14.28	13.79	23.08	8.33	16
20	80	92.86	86.21	100	100	100	92.31	91.67	92
21	86.67	92.86	89.65	100	100	100	92.31	100	96
22	73.33	71.43	72.41	93.33	64.29	79.31	92.31	83.33	88
23	73.33	50	62.07	80	64.29	72.41	84.61	83.33	84
24	26.67	64.29	44.83	26.67	50	37.93	15.38	41.67	28
25	93.33	78.57	86.21	66.67	100	82.76	92.31	83.33	88
26	60	57.14	58.62	60	50	55.17	84.61	75	80
N	15	14	29	15	14	29	13	12	25

Note: Cards that were correctly identified less than 70% of the time for the combined totals are shaded grey.

Table 12 indicates that several cards were correctly identified less than 70% of the time. These cards were 8 (frustrated/stuck), 10 (suspicious/sly), 11 (numb/empty/blank), 18 (strong/powerful), 19 (disgust/yuk), 23 (aggressive/abusive), 24 (exhausted/tired) and 26 (shy/embarrassed). These cards were also identified in the PFI manual as being problematic for young children. Interestingly, as evidenced by data in both Table’s 10 and 11, children of the current study, all of whom were admitted to the study due to fear responses following conflict, struggled to identify the numb/empty/blank face on card 11, and rather tended to incorrectly label it as depicting a negative emotion such as sad, confused, cross, or nervous for example.

In order to test the hypothesis that children of conflictual parental separation and divorce would be significantly worse at correctly identifying facial emotions than the normative sample data reported in the PFI manual, a single-sample t-test was carried out. From the normative data provided in the PFI manual, the mean number of cards correctly identified by ‘normal’ children aged 5 - 12 was 23.2623. This figure was used as a comparison mean for the t-tests. Results are presented in Table 13 below.

Table 13. Mean number of PFI cards correctly identified at intake, post and follow-up assessments, delimited by condition, and indicating those mean scores that differed significantly from normative data.

	Intake	Post	Follow-Up
CBT	19.67 **** (1.40)	20.80 *** (1.82)	21.38 ** (1.98)
Bibliotherapy	19.78 *** (2.45)	21.57 ** (1.87)	21.92 * (1.62)

Note: **** = $p < .0001$, *** = $p < .001$, ** = $p < .01$, * = $p < .05$.

Table 13 indicates that the mean number of PF cards correctly identified by the current sample, was consistently significantly worse than the normative sample, at all time points, and for both conditions. Scores did however; show a move towards the normative mean over time. Further analyses were conducted in order to test whether these changes were significant.

A Repeated Measures ANOVA examining mean number of PFI cards correctly identified at intake and post, for each condition, revealed no significant interaction ($F(1, 27) = 0.81, p = ns$).

This indicated that neither condition was more effective than the other at improving PFI total scores. An effect of time, regardless of condition was observed ($F(1, 27) = 16.32, p < .001$), indicating that regardless of condition, PFI scores improved significantly from intake to post.

A Repeated Measures ANOVA was again conducted, this time examining data from post to follow-up assessments. No significant interaction was found ($F(1, 23) = 0.25, p = ns$), indicating that neither condition was more effective at improving PFI scores from post to follow-up assessments. In addition, there was no significant effect of time ($F(1, 23) = 0.60, p = ns$) or condition ($F(1, 23) = 1.01, p = ns$).

Children were also asked to rate how often they felt like the person in each card, regardless of whether they could accurately describe the feeling shown. Mean scores from the 4-point Likert scale were calculated and are shown in Table 14. Higher scores indicate that the child reported a higher degree of that feeling.

Table 14. Mean scores and Standard Deviations for the question; ‘How often do you feel like the person in this card’ for each PFI card, delimited by condition and assessment time point.

PFI	CBT						Bibliotherapy					
	Intake	<i>n</i>	Post	<i>n</i>	Follow up	<i>n</i>	Intake	<i>n</i>	Post	<i>n</i>	Follow up	<i>n</i>
1	2.53 (0.91)	15	1.40 (0.83)	15	2.00 (1.29)	13	2.14 (1.10)	14	2.00 (0.68)	14	1.75 (0.45)	12
2	3.40 (0.83)	15	3.73 (0.80)	15	3.77 (0.44)	13	3.14 (0.95)	14	3.21 (0.97)	14	3.33 (0.78)	12
3	2.67 (1.29)	15	3.40 (0.91)	15	3.15 (0.99)	13	2.50 (1.02)	14	3.00 (1.11)	14	2.42 (1.08)	12
4	2.20 (1.26)	15	1.73 (0.96)	15	1.75 (1.14)	12	2.08 (0.95)	13	2.36 (1.15)	14	2.00 (0.85)	12
5	1.87 (1.24)	15	1.33 (0.49)	15	2.23 (1.36)	13	2.14 (1.03)	14	2.00 (1.04)	14	2.08 (1.08)	12
6	2.00 (1.19)	15	1.33 (0.49)	15	1.69 (0.85)	13	2.08 (0.79)	12	1.92 (1.04)	13	1.83 (0.72)	12
7	1.79 (1.12)	14	1.43 (0.85)	14	1.46 (0.97)	13	1.71 (0.73)	14	1.92 (0.86)	13	1.42 (0.67)	12
8	2.33 (1.29)	15	1.47 (0.91)	15	1.77 (1.30)	13	1.38 (0.96)	13	1.78 (0.97)	14	1.54 (0.93)	11
9	1.87 (1.19)	15	1.07 (0.26)	15	1.61 (0.87)	13	2.07 (1.00)	14	1.71 (0.91)	14	1.83 (0.72)	12
10	2.14 (1.23)	14	1.85 (0.90)	13	1.83 (1.03)	12	1.78 (0.58)	14	1.50 (0.76)	14	1.64 (0.81)	11
11	2.33 (1.41)	9	1.73 (1.10)	11	1.90 (1.20)	10	1.78 (0.97)	9	1.44 (0.88)	9	1.44 (0.73)	9
12	3.28 (1.07)	14	3.47 (0.91)	15	3.61 (0.77)	13	2.93 (1.00)	14	2.86 (1.03)	14	2.58 (1.08)	12
13	1.87 (1.19)	15	1.47 (1.06)	15	1.61 (0.96)	13	2.29 (1.32)	14	1.79 (1.05)	14	1.58 (0.79)	12
14	1.87 (1.24)	15	1.40 (0.83)	15	1.61 (0.96)	13	1.86 (1.10)	14	1.86 (0.86)	14	1.67 (0.89)	12
15	1.87 (1.24)	15	1.67 (0.90)	15	1.54 (0.88)	13	2.00 (1.08)	13	1.43 (0.51)	14	1.50 (0.52)	12
16	2.73 (1.16)	15	3.27 (0.96)	15	3.77 (0.60)	13	2.57 (1.16)	14	2.78 (1.05)	14	2.33 (0.98)	12
17	1.93 (1.22)	15	1.00 (0.00)	15	1.46 (0.97)	13	1.85 (0.90)	13	1.50 (0.52)	14	1.75 (0.87)	12
18	2.73 (1.35)	11	2.87 (1.89)	15	2.91 (1.37)	11	2.36 (1.08)	14	2.54 (1.20)	13	2.08 (1.08)	12
19	1.67 (0.90)	15	1.85 (1.14)	13	1.31 (0.48)	13	1.61 (0.96)	13	1.42 (0.67)	12	1.80 (0.63)	10
20	1.80 (1.08)	15	1.93 (1.10)	15	2.00 (1.15)	13	2.07 (0.10)	14	1.50 (0.52)	14	1.75 (0.87)	12
21	2.92 (1.32)	13	3.07 (1.07)	14	3.83 (0.39)	12	2.15 (1.28)	13	2.64 (1.15)	14	1.92 (1.08)	12
22	1.69 (1.11)	13	1.40 (0.83)	15	1.61 (1.12)	13	2.08 (1.19)	13	1.83 (1.03)	12	1.25 (0.45)	12
23	1.93 (1.03)	15	1.50 (0.94)	14	1.75 (0.87)	12	1.69 (0.85)	13	2.00 (0.77)	11	1.36 (0.50)	11
24	1.80 (0.94)	15	1.27 (0.80)	15	1.46 (0.88)	13	2.07 (0.92)	14	1.77 (1.01)	13	1.83 (0.58)	12
25	2.00 (1.19)	15	1.20 (0.77)	15	1.77 (1.16)	13	2.00 (1.11)	14	1.86 (0.77)	14	1.92 (0.79)	12
26	2.00 (1.04)	14	1.80 (1.15)	15	1.58 (0.10)	12	1.75 (1.14)	12	1.85 (0.99)	13	1.42 (0.67)	12

It was thought that the quantitative data from the question ‘How often do you feel like the person in this card’ might be utilised as an outcome measure across groups. Card 1 (sad / depressed) and card 2 (happy / content) were chosen for further testing due to the high degree of accuracy at which the children were able to identify both cards correctly, coupled with the thought that these cards were less ambiguous in their meaning than some of the others. The PFI had not been used in this context before.

A Repeated Measures ANOVA was conducted for cards 1 and 2, examining changes from intake to post. This analysis is displayed in Table 15. Repeated Measures ANOVA’s were also conducted examining these same cards from post to follow-up assessments, and results are displayed in Table 16. Reader please note that Mean’s and Standard Deviations shown here differ slightly from those presented in Table 14, as only the data of those participants who completed each card at both time points were included in the Repeated Measures ANOVA’s.

The Repeated Measures ANOVA revealed that children in the CBT condition were significantly more likely to report a lessening in their frequency of feeling ‘sad / depressed’ following the therapy program, than their Bibliotherapy group counterparts. This interaction is displayed in Figure 11. Table 15 indicates that there was no such significant effect for PFI card 2 (happy / content).

As indicated in Table 16, a significant interaction was observed for PFI card 1, from post to follow-up assessments. Upon inspection of group means, and as displayed in Figure 12, the CBT group was significantly more likely to report an increase in frequency of the ‘sad/depressed’ feeling portrayed in card 1, by the follow-up assessment. This was a similar trend to that observed in PTSD symptom scores and CPICS Intensity scores, which consequently disappeared when data was reanalysed *excluding* those children who had reported a recent incident of parental conflict prior to the follow-up assessment. No significant effects were observed for PFI card 2 (happy / content) from post to follow-up assessments. The following section (page 109) will examine PFI card 1 data, *excluding* those children who reported recent parental conflict.

Table 15. Results of Repeated Measures ANOVA examining changes in scores on cards 1 and 2 from INTAKE to POST assessments for the question: How often do you feel like the person in this card?

PFI #	CBT			Bibliotherapy			Condition	Time	Interaction
	Intake	Post	<i>n</i>	Intake	Post	<i>n</i>			
1 (sad / depressed)	2.53 (0.91)	1.40 (0.83)	15	2.14 (1.10)	2.00 (0.68)	14	0.15	11.60 **	6.99 *
2 (happy / content)	3.40 (0.83)	3.73 (0.80)	15	3.14 (0.95)	3.21 (0.97)	14	1.93	1.32	0.55

Note: ** = $p < .01$, * = $p < .05$

Table 16. Results of Repeated Measures ANOVA examining changes in scores on cards 1 and 2 from POST to FOLLOW-UP assessments for the question: How often do you feel like the person in this card?

PFI #	CBT			Bibliotherapy			Condition	Time	Interaction
	Post	Follow-up	<i>n</i>	Post	Follow-up	<i>n</i>			
1 (sad / depressed)	1.15 (0.37)	2.00 (1.29)	13	2.00 (0.60)	1.75 (0.45)	12	1.05	2.32	7.86 *
2 (happy / content)	3.69 (0.85)	3.77 (0.44)	13	3.08 (0.10)	3.33 (0.78)	12	3.90	0.89	0.25

Note: * = $p < .05$

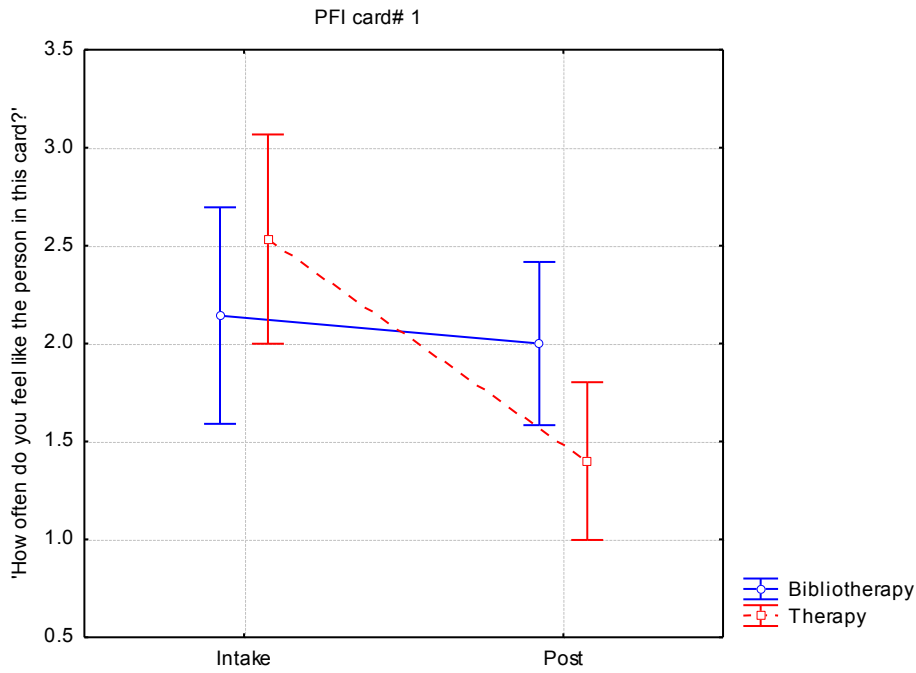


Figure 11. Plot of interaction effect for scores on PFI card 1, from INTAKE to POST, for the question How often do you feel like the person in this card.

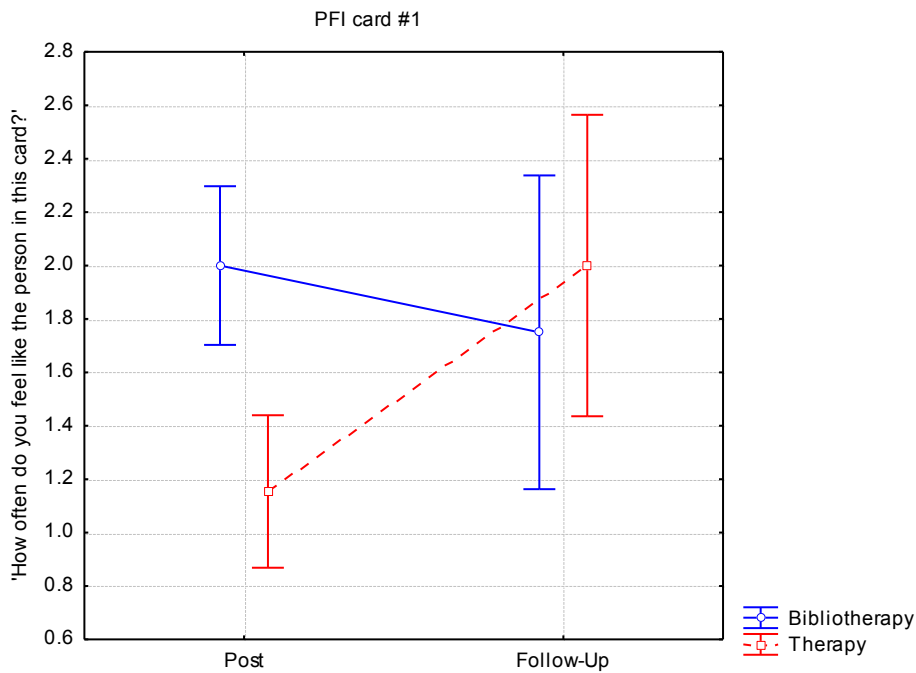


Figure 12. Plot of interaction effect for scores on PFI card 1, from POST to FOLLOW-UP, for the question How often do you feel like the person in this card.

Re-analysis of PFI card #1 (sad/depressed) data excluding cases who reported a recent incident of parental conflict.

A decision was made to reanalyse the PFI card 1 data, this time excluding those children who reported a recent incident of severe parental conflict. A Repeated Measures ANOVA revealed that the exclusion of these cases still resulted in the CBT children being significantly more likely to report an increase in feelings of ‘sad/depressed’ than the Bibliotherapy children, as can be observed in Table 17.

Table 17. Results of a Repeated Measures ANOVA examining changes in scores on PFI card 1 from POST to FOLLOW-UP assessments, *excluding* those children who reported a recent incident of parental conflict.

	CBT			Bibliotherapy			Condition	Time	Interaction
	Post	Follow-up	<i>n</i>	Post	Follow-up	<i>n</i>			
PFI card 1 (sad/depressed)	1.12 (0.35)	2.12 (1.36)	8	1.80 (0.42)	1.70 (0.48)	10	0.25	3.41	5.09 *

Note: * = $p < .05$

It can be tentatively suggested that the occurrence of a recent parental conflict was not responsible for the significant rise in feelings of the ‘sad/depressed’ feeling depicted in card 1 of the PFI, for the CBT group. It should be noted that mean scores for the CBT group moved from around 1 (which indicated that most CBT children indicated feeling this emotion ‘hardly ever/very little’) to just over 2 (indicating a change towards ‘sometimes/moderately’ feeling this emotion). Qualitatively, this change is not particularly alarming.

6.5. Discussion.

The aim of the current study was to examine the efficacy of a 7-week Trauma-Focused Cognitive Behavioural Therapy program, on measures of PTSD, depression, anxiety, perception of interparental conflict, internalising behaviours and externalising behaviours, in children displaying fear reactions following a highly conflictual parental separation. It was

specifically hypothesised that children taking part in the CBT program would improve significantly more on these measures than children taking part in a Bibliotherapy control condition, from the intake assessment to the post-treatment assessment (Hypothesis 1), and that these therapeutic gains would be maintained at a three-month follow-up (Hypothesis 2). In addition, it was hypothesised that these therapeutic gains would be not only statistically significant, but of reliable and clinical significance also (Hypothesis 3). It was hypothesised that parental ratings of happiness with their relationship with their child, would be related to more positive outcomes at post and three-month follow-up assessments (Hypothesis 4). Lastly, it was hypothesised that children from conflictual parental separation, would be significantly worse at accurately identifying facial emotions on the Pictured Feelings Instrument, in comparison to the normative sample statistics reported in the Pictured Feelings Instrument manual (Schack Stone, 2004; Hypothesis 5).

Overall, the CBT program was found to be a successful short term treatment for children showing fear reactions following a conflictual parental separation. There were however, some limitations to this finding that will be discussed further throughout the discussion.

Chapter 6.5 will examine each main outcome measure separately, drawing comparisons between the performances of children in both conditions. The relevance of reliable and clinical change analyses will also be discussed. The impact of parent/child relationship happiness on healthy adjustment to parental separation will be further discussed, along with findings from the Pictured Feelings Instrument. Lastly, the findings will be summarised and discussed more broadly, study limitations will be considered, followed by concluding remarks.

6.5.1. Overview of key findings.

PTSD Symptom Score and Daily Functioning.

Irrespective of condition, both PTSD symptoms and daily functioning significantly improved from intake to post-treatment assessments. The CBT program was superior at significantly improving PTSD symptoms, than the Bibliotherapy program, from intake to post. In addition, the CBT program resulted in a significantly higher proportion of children reliably moving from

a clinical to a more normal PTSD symptom range. The CBT program was also superior at improving daily functioning than the Bibliotherapy condition.

These findings provided the first evidence that a 7-week CBT program can be effective at significantly ameliorating symptoms of PTSD and improving daily functioning in children showing fear reactions following a conflictual parental separation. These findings are in keeping with past research that has investigated the efficacy of similar CBT programs in children who have experienced sexual abuse (Deblinger, Lippmann, & Steer, 1996; King, et. al., 2000; Cohen, Deblinger, Mannarino, & Steer, 2004), traumatic grief (Cohen, Mannarino & Knudsen, 2004b; Cohen, Mannarino, & Staron, 2006b), varied single-incident traumas (Smith et. al., 2007) an earthquake (Shooshtary, Panaghi, & Moghadam, 2008), domestic violence (Tucker, 2010) and child abuse (Feather & Ronan, 2006, 2009; Runyon, Deblinger & Schoeder, 2009).

However, in contradiction to the hypothesis that scores on all measures would remain stable from post-treatment to follow-up assessment, the CBT group was actually significantly more likely to show a worsening of symptoms, than the Bibliotherapy group, from post-treatment to follow-up assessment. On closer inspection of the data, it was found that five CBT and two Bibliotherapy children had experienced a recent severe incident of parental conflict involving verbal conflict, physical abuse against the parent, and/or physical abuse against the child. Re-analysis of the data, excluding these cases, revealed no significant difference in groups from post to follow-up assessments. That is, scores remained stable following therapy, in those that did not experience any new parental conflict.

In addition, reliable and clinical change analyses of PTSD scores (including all cases whether new parental conflict had occurred or not) revealed that there was no significant difference between groups, from post to follow-up assessment in terms of clinical status. This indicated that although PTSD symptom scores did increase in the CBT group (when including all cases), there was no significant difference between groups in terms of clinical change. The occurrence of recurrent parental conflict will be discussed further in the Limitations section (6.5.3).

Anxiety.

Anxiety scores, regardless of condition, significantly improved over time from intake to post-treatment assessments. There was no significant effect of time from post to follow-up assessments, indicating that therapeutic gains were maintained over the three months after treatment. The CBT condition was significantly better at improving anxiety than the Bibliotherapy condition, from intake to post-treatment, indicating that CBT is an effective treatment for anxiety following a conflictual parental separation. It should be noted however, that clinical change analyses revealed that neither condition was more likely than the other, to produce more *clinically* significant improvements. That is, although scores reduced markedly in the CBT group, participants did not necessarily enter a normal range of anxiety- they may have, for example, moved from a high clinical score to a low clinical score. While this is still a very good outcome, it should be noted that while this CBT program was effective at treating anxiety, it did not entirely ameliorate anxiety.

Other past research, examining the efficacy of similar CBT programs, has also found a significant decrease in anxiety in CBT groups, in comparison to control groups (King, et. al., 2000; Cohen, Mannarino & Knudsen, 2005; Cohen, Mannarino & Knudsen, 2004b; Smith et. al., 2007). The current research found support for CBT as an effective treatment of anxiety in children showing fear reactions following a conflictual parental separation. Support was also found for the hypothesis that improvements in anxiety would be maintained at follow-up.

Depression.

Overall depression scores, regardless of condition, showed a significant improvement over time, from intake to post-treatment assessment. However, no condition was significantly more likely to produce an improvement in depressive symptoms than the other, either from intake to post-treatment or from post-treatment to follow-up. This was contrary to past research findings, in which CBT programs have indicated strong improvements in depressive symptoms (Cohen & Mannarino, 1998b; Deblinger, Lippmann, & Steer, 1996; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005; Cohen, Mannarino, & Knudsen, 2004b; Smith et. al., 2007). There was no support found for the hypothesis that the CBT condition

would be more effective at ameliorating depressive symptoms than the Bibliotherapy condition, in children showing fear reactions following a conflictual parental separation. Neither condition produced a significant improvement in depression. This may be explained by the fact that at intake mean scores on the CDI were well below the clinical cut off of 19 for the CBT ($M = 10$) and Bibliotherapy ($M = 11.21$) groups, leaving little room for significant improvement.

Perception of Interparental Conflict.

Regardless of condition, there was an overall significant improvement on the CPICS measures of conflict frequency, intensity, resolution, content, threat and coping efficacy, but not self blame, from intake to post-treatment assessment. Given that scores on the self blame sub scale were initially extremely low, the lack of any significant effect of time was not surprising. However, neither condition was significantly more likely to improve any of the interparental conflict subscales from intake to post.

Upon examination of scores on the CPICS subscales from post to follow-up, a significant effect of time, regardless of condition, was observed for frequency of conflict. This indicated that regardless of condition, an overall effect of time indicated a significant increase in the frequency of parental conflict.

It was also revealed that the CBT condition was significantly more likely to result in an increase in conflict intensity, following completion of the program. This was of concern to the investigators. Upon inspection of the data (and as mentioned in the PTSD section above), several participants had been exposed to a recent serious parental conflict involving verbal abuse, physical abuse against a parent or family member, and/or physical abuse against themselves, since completion of the program. Further analyses, excluding these cases, revealed no significant change in CPICS intensity scores from post-treatment to follow-up assessment. That is, CPICS scores remained low in those that did not experience an incident of recent parental conflict. The impact of recent parental conflict will be further discussed in the Limitations section (6.5.3).

To conclude, no support was found for the hypothesis that the CBT program would be significantly better at producing improvement in children's perceptions of interparental conflict, than the Bibliotherapy condition.

Internalising Behaviour.

An examination of all participants, regardless of condition, revealed a very significant reduction in internalising behaviour from intake to post-treatment assessment. There was however, no indication that one condition was better than the other at reducing internalising behaviours, reported by the participating parent.

When examining internalising scores from post-treatment to follow-up assessment, an overall significant reduction was observed, regardless of condition. Upon further examination, it was found that the CBT program was significantly better at reducing internalising behaviours than the Bibliotherapy condition, from post-treatment to follow-up assessment.

Support was found for the hypothesis that the CBT condition would be significantly better than the Bibliotherapy condition, at ameliorating internalising symptoms, however, the significant difference between groups was observed from post to follow-up, rather than from intake to post. These findings support past research that found CBT to be an effective treatment for internalising symptoms following trauma (Cohen & Mannarino, 1996).

Externalising Behaviour.

There was no support found for the hypothesis that the CBT condition would be significantly better at reducing externalising behaviours, than the Bibliotherapy condition. This was in contrast to past findings (Cohen & Mannarino, 1996; Deblinger, Lippmann & Steer, 1996). There were no significant effects of time, or condition on externalising behaviour scores, at any time point. Neither condition was significantly better at reducing externalising behaviours.

Parent / Child relationship happiness.

Correlation analyses revealed no significant relationship between parent perceptions of happiness with their relationship with their child, and any outcome measure. There were however, several moderate relationships that approached significance and are worthy of further mention. For example, there was a moderate tendency for CBT children whose parents rated their relationship with them as higher in happiness, to have a tendency to report fewer externalising behaviour problems. This trend occurred at all assessments for the CBT children. For the Bibliotherapy children, this same relationship occurred only at intake and follow-up assessments. At the post assessment, there was only a very weak relationship observed.

Correlational findings for the Bibliotherapy children were mixed. For example, there was a tendency for a happier parent/child relationship to be related to worse symptoms at intake on measures of anxiety and PTSD, and at post on measures of anxiety, depression and PTSD. This contradicted predictions based on prior research that indicated a strong, communicative bond with a parent, could aid healthy adjustment throughout parental separation (Hetherington, 2003).

Overall, the PFI allowed for an interesting insight in to what the children taking part in the program, were actually feeling at each assessment point. There appears to be no other research examining CBT efficacy in children that also employed a facial emotion recognition measure. The PFI measure is relatively new and requires extensive testing of its psychometric properties. For example, the current study indicated that some cards are not easily understood by young children, with many varied responses to some of the more ambiguous cards.

As predicted, children taking part in the current research were significantly worse at recognising facial emotions, at all time points, than the ‘normal’ children who were tested in order to form the PFI manual norms (Schack-Stone, 2004). Tests revealed that while accuracy improved over time from intake to post assessments, this was not dependent on condition.

Responses to the question ‘How often do you feel like the person in the card?’ for card #1 (sad/depressed), revealed the very same trend over time as PTSD symptom scores and CPICS intensity. That is, while the CBT condition was more likely than the Bibliotherapy condition to

produce a significant decline in feelings of ‘sad/depressed’ from intake to post, the opposite effect was observed from post to follow-up assessment, with CBT participants indicating a sharp and significant increase. Unlike PTSD symptoms and CPICS Intensity scores, this trend was not linked to the occurrence of recent parental conflict. That is, even when cases of recent parental conflict were excluded from analyses, the significant trend persisted. This result will be further discussed below.

6.5.2. Explanation of Findings.

Results of the current study indicated that recurring parental conflict provided a substantial confounding factor in the interpretation of three month follow-up data. The aim of the CBT program was to treat fear symptoms *following* a trauma. Post-treatment results indicate that this was achieved. However, the program was not designed to prevent further fear symptoms in the case of a new trauma- in this case, new parental conflict. This was reflected by the significant increase in PTSD symptoms at the three-month follow-up assessment, along with a significant increase in the frequency of conflict reported by the children of the CBT condition. The author could not find any past research that has examined effective treatments for PTSD symptoms that recur following new trauma. That is, there doesn't appear to be any form of therapy designed to not only treat current PTSD symptoms, but also prevent further PTSD symptoms in the event of a new trauma. It would appear that typically, if a patient were to experience a new trauma, and redevelop PTSD symptoms, they would seek further treatment. The treatment utilised in the current study, indicated that significant therapeutic gains were achieved, but that PTSD symptoms were likely to return following another high conflict event between parents. As previously described (Moskowitz, 1998), parental conflict can continue long after a separation or divorce. This was a major confounding factor of the present study. Results suggest that children, who experience a highly conflictual parental separation, will require not only immediate treatment, but ongoing support.

Often with other traumas, such as sexual or physical abuse, the child will be removed from the abusive situation before therapy is commenced. In the case of natural disasters or car accidents for example, the likelihood of a recurrence is usually quite small. Parental conflict, as a form of trauma, is quite different, in that research shows a tendency for separated spouses to have

continuing conflict for several years (Moskowitz, 1998). This complicates the issue of treatment, since the aim of therapy needs to not only be to ameliorate immediate symptoms of distress, but to also provide some sort of ‘resilience training’ in order for these children to cope better with future conflict exposure. Other research has examined the efficacy of resilience training in preventing PTSD in the Police Force (Varker, Cook, & Devilly, in preparation); however, there appears to be no resilience training research in child samples. The current parent group program did in fact provide some focus on ‘helping children cope with further conflicts’ (refer to Appendix C) however this was limited to a brief discussion in the final parent group session. It would seem that the current CBT program needs to allocate more time to this area - perhaps spending several sessions solely focusing on ‘preparing for future stressful events’ would be of great value.

In addition, it is important for parents to be made aware of the deleterious consequences of their child’s exposure to conflict. The parent group of the current CBT program, dedicated several sessions to discussing topics such as ‘The impact of the conflict on my child and what I can do,’ and ‘Reducing the conflict’ in order to achieve exactly this. The issue however, was that only one parent per child, took part. The project manager (and author of this thesis) found in phone calls with the other parents not taking part, that most were indifferent to the program and had very little interest or were even quite negative about the program as a whole. It was therefore not possible to provide the same information about the deleterious consequences of childhood exposure to parental conflict to the other non-participating parent. Many participating parents expressed their frustration at the difficulty in trying to reduce conflict with an ex who had seemingly very little desire to stop the conflict. In addition, often the children themselves would report that their non-participating parent would try to ‘get them onside’ by complaining about the participating parent. When children are implicated in conflict like this, and are pressured to take sides, research indicates a higher tendency towards depression, anxiety and aggression (Buchanan et. al., 1991).

This may help explain why following what seemed to be an effective CBT program, children who were exposed to a new episode of parental conflict, experienced an increase in PTSD symptom levels. It might also be the case that ratings on PTSD symptoms were high because the trauma was relatively recent. It would be of interest to see if after several trauma-free

months, PTSD symptoms showed a naturally recovery back to a normal range. This was unfortunately outside the parameters of the current study.

It was found by Smith and colleagues (2007), that over a 4-week symptom monitoring period, 9 out of 36 children (24%) who had been exposed to a trauma, no longer met PTSD criteria. Smith and colleagues suggested that symptom monitoring may be of potential therapeutic value. It is possible that the discussion and acknowledgement of symptoms and experiences that occurs when being assessed following trauma, might in itself act as a mild form of gradual exposure. Smith and colleagues suggested that symptom monitoring may be useful for child trauma victims who display mild PTSD symptoms, and no impairment of functioning. Such monitoring would allow for the identification of children whose symptoms deteriorate if another trauma does occur, and would have been a valuable inclusion in the current study.

Additionally, given that research by Smith and colleagues (2007) demonstrated a marked tendency for a natural recovery to be made in 24% of trauma exposed children meeting PTSD criteria, it cannot be entirely ruled out that improvements from intake to post were not due to this natural process of recovery, rather than therapy alone. Although current and past researchers have declined use of a wait list control group based on ethical reasons, the use of a waitlist control would be the most effective way to factor out natural symptom improvement, and confidently estimate the true effectiveness of therapy.

From intake to post, regardless of condition, there was a significant improvement in almost all facets of perception of interparental conflict. This indicated that neither condition was significantly more likely than the other to result in improvement, but that both were effective. The similar performance of both conditions was surprising given that parents whose children took part in the CBT condition attended a 5 week manualised parenting program that had a strong focus on reducing interparental conflict. We predicted that children of parents who attended this intensive program would report a more significant reduction in interparental conflict than their Bibliotherapy counterparts (Hypothesis 1). It appears however, that the parents who read ‘_Mom’s House, Dad’s House’ (Ricci, 1997) performed equally well. It is possible that adults are capable of taking a successful, independent approach to conflict reduction. In fact, many parents of the Bibliotherapy condition expressed relief that they could take the book home and adopt their own comfortable, private approach to dealing with the

aftermath of their conflictual separation. The book was found to be a helpful means of reducing conflict, and parental feedback to the investigators was consistently positive. Results did indicate that parents unable to attend a concurrent parenting program, might still receive some benefit from reading this book. This would certainly be beneficial in instances where time and financial constraints exist. However, while reductions in interparental conflict were of course a very positive outcome, the reading of the book by their parents - and subsequent implementation of the book's advice - was not enough for children of the Bibliotherapy condition to indicate a significant lasting improvement in symptoms of PTSD, anxiety or internalising behaviours. Treatment for these children would still be necessary.

It is important that therapy is both effective and efficient (Shooshtary, Panaghi, & Moghadam, 2008). Hence, part of the aim of the current study was to test a shorter therapy program than most, to see if results could be achieved in a quicker time frame. Significant improvements were obtained within seven CBT sessions for symptoms of PTSD and anxiety, and by the 3-month follow-up for internalising behaviours, but not for externalising behaviours. It should be considered that of all past research that has tested the efficacy of a CBT program in treating trauma exposed children, not a single study observed significant improvement in ALL outcome measures. This reflects the reality that a treatment program cannot always treat all possible symptoms. Trauma reactions are complex (Dyregrov & Yule, 2006; Eth & Pynoos, 1985) and to expect global improvements in symptoms, may be asking too much. Overall, the current study found that a manualised 7-week TF-CBT program was an effective treatment for children showing fear reactions following a conflictual parental separation, but that continued monitoring of these children is necessary given the recurrent nature of parental conflict.

Parents perceived happiness with their relationship with their child at intake into the program, was found to be moderately related to reduced externalising behaviours in children partaking in the CBT condition at all assessment time points, and in the Bibliotherapy condition at intake and follow-up assessments. There are several reasons for this occurrence. Externalising behaviours, as measured by the CBCL, include rule-breaking and aggressive behaviours. One could assume that a child with a higher degree of externalising behaviours would elicit much more difficult behaviour for a parent to cope with, than a child who is depressed, withdrawn, or indicates a tendency towards a more internalising behavioural style. This may explain why parents with children rating higher on externalising behaviours, rated their relationship with

their child as less happy. Given that there were no significant changes in externalising behaviour over time for either condition, we cannot make predictions as to whether the ameliorating of externalising symptoms would result in an increase in parental happiness with their child. This would be worth further exploration in future trials but would require the development of a comprehensive, psychometrically sound measure of parent/child relationship happiness.’

It is unknown why increased parent/child relationship happiness was related to an increased tendency towards higher levels of anxiety, depression and PTSD symptoms at several time points for the Bibliotherapy children. There was no such tendency observed in children taking part in the CBT condition. A study utilising larger group numbers is required before directional statements can be made regarding the effect of parent/child relationships on child adjustment to separation. This area is simply not well enough understood. In addition, the current study used just one broad question to gauge parental happiness with their relationship with their child. Future research would benefit from the use of a more comprehensive measure of parent/child happiness.

The use of the PFI provided an extra dimension to the current study. It would be very valuable to include a measure of facial emotion recognition in future research examining treatment efficacies in children, particularly given that facial emotion recognition ability is closely linked to neural abnormalities (Cicchetti & Curtis, 2005) and poor psychiatric health in children (Pollack, Cicchetti, Klorman, & Brumaghim, 1997; Pollack et al., 2001). The PFI testing in the current study was essentially a pilot investigation, given that this instrument has not been widely tested, and has not been used in this context previously. An interesting point to be noted is that card #11 (numb/empty/blank) had a very low rate of correct identification, and children did typically label this neutral face as showing a negative emotion. It has been suggested that children who come from difficult, stressful circumstances such as low-income families, or abusive circumstances, may tend to incorrectly interpret neutral faces as showing negative emotions such as fear or anger (Herba & Phillips, 2004) and that this may explain increased tendencies towards aggression and conduct problems in these children (Dadds et al., 2006; Dodge, Price, Bachorowski, & Newman, 1990; Dodge, Pettit, Bates, & Valente, 1995). It might be that this trend is visible in the current sample, although with only one ‘neutral’ test card, and no control group to compare scores against, there is not enough evidence to draw any firm

conclusions. Other measures that test several examples of neutral faces would be beneficial for inclusion in future research, so that the relationship between trauma occurrence and incorrect interpretation of emotions can be further examined. It may be that the misinterpretation of neutral faces can differentiate between clinical and non-clinical groups, however, the current study did not allow for such an examination, given that we did not have our own normative sample for comparison, and only one PFI card depicted a neutral face.

Children from both conditions indicated a tendency for recognition scores on the PFI to increase overtime. This is likely due to the natural increase in emotional recognition that occurs with age (Boyatzis, Chazan, & Ting, 1993; Philippot & Feldman, 1990). The fact that children's reported levels of sadness (PFI card #1) varied in a very similar fashion to PTSD symptom scores over time, suggests that the two constructs are quite likely related. Not only does the current study provide evidence that PTSD symptoms scores increased following reoccurring trauma, but that ratings of sadness also similarly increased.

6.5.3. Limitations.

While the program was shown to be effective, there were some clear limitations. The most obvious limitation was that parental conflict had a tendency to reoccur, and this was associated with an increase in PTSD symptoms and reported parental conflict intensity. As was previously discussed, children of conflictual parental separation are a unique group with different needs to children who have been victims of other forms of trauma. Continued regular symptom monitoring would be a wise step to ensure that if another incident of severe conflict were to occur, the child could receive assistance immediately. The recurrent nature of conflict even years after divorce is unfortunate, and unlikely to change unless the parents actively aim to reduce it. It may therefore not be realistic to aim to stop parental conflict altogether, but rather, it may be a more realistic goal to provide assistance to effected children, by treating current symptoms, providing strategies and advice on dealing with future conflict, and maintaining regular therapist contact. Coupled with parental involvement in therapy as well as parental education about the effects of conflict exposure on children, this strategy could be quite effective. The results of the current study support this approach.

Despite the use of stratified random group allocation, there was a significant difference in age of the children between groups; with the CBT group being significantly younger than the Bibliotherapy group (CBT; $M = 6.93$, $SD = 1.44$. BIB; $M = 9.43$, $SD = 1.99$). It is unclear what effect this may have had on results, if any. The inclusion of age as a covariate in analyses was not possible due to age having no relationship with any of the outcome measures. Therapy content was always simple enough for the youngest to comprehend, although it is possible that concepts were more quickly understood by older children. Other studies have found a CBT program to be effective across an even broader age range than that of the current study – King and colleagues (2000), for example, tested 36 children whose ages ranged from 5 to 17, with positive results. The children of the Bibliotherapy condition were not significantly better than the CBT children at recognising the feelings depicted in the PFI cards, despite being significantly older. This is unusual given prior research has indicated that ability to recognise facial emotions is positively correlated with age throughout childhood (Boyatzis, Chazan, & Ting, 1993; Philippot & Feldman, 1990; Schack Stone, 2004). The imbalance of age across groups was unfortunate and unforeseeable given the randomised design of the study, and lends further credence to using a larger sample in future replications which would make such an occurrence more unlikely.

The term ‘conflictual parental separation’ encompasses a wide array of possible circumstances. The experiences of a child in either condition could have varied from the witnessing of parental verbal conflict, to a child being physically assaulted by a parent during the conflict. Unfortunately the current study did not document the entire range of potential forms of parental conflict or personal abuse the child may have been exposed to, nor did it examine current levels of conflict reported by the parents. Therefore, it is impossible to know whether the severity of traumatic experiences of children across both conditions were equal. In addition, prior trauma history, outside of parental conflict was not assessed and was only addressed in therapy if a parent happened to offer the information. Again, a much larger sample size would allow for families from all forms of parental conflict to be represented and perhaps even compared and analysed separately. This would help determine what conflictual or traumatic setting the therapy is most apt in treating the resultant symptoms of, and would allow for identification of families who may find more assistance with referral elsewhere. Additionally, a larger sample size would allow for more power of the analyses which would give a clearer indication of

subtle differences that may exist within groups. Recruitment of a larger sample size was unfortunately not possible due to limited resources.

There may have been some response bias present in the data. As was found in earlier research (Cohen & Mannarino, 1996), children displayed a tendency to respond with ‘good’ even when their parent had reported severe difficulties in the area under question. It is quite possible that children from parents with a high level of conflict are accustomed to responding more favourably, as a means to reduce the chances of conflict and emotional upset within their own home. For example, a child might tell their mother that a stay at their father’s house was ‘good,’ regardless of whether or not this was in fact the case - in order to not upset their mother. This type of response pattern might become quite regular and it is possible that this response bias is present in the current data. For example, other research has shown depressive symptoms to consistently co-occur with PTSD symptoms however, scores on depression were remarkably low in the current study. Children of the current study may have responded more favourably out of habit, or simply to present as more likeable. There is no indication that either group was more susceptible to this bias than the other.

All three therapists who assisted children in completing the CPSS reported that the children often required further explanation of the questions posed, and suggested that the CPSS was too difficult for young children to comprehend. In particular, children often failed to understand the rating scale (0 = none or only at one time, 1 = Once a week or less/once in a while, 2 = 2 to 4 times a week/half the time, 3 = five times per week/almost always) and required constant reminding of what was being asked. This measure would not be recommended for very young children, as it is possible, that through lack of understanding, the results may not have provided an accurate profile of PTSD symptoms. Behavioural observations coupled with parental rating of their child’s PTSD symptoms might be more appropriate in future. Also, an assessment of all types of trauma exposure that the child had been subjected to, would be a worth inclusion in future research.

In addition, therapists on several occasions reported that children had difficulty comprehending the questions of the CPICS, and often became bored. It was frequently a struggle for children to complete this instrument. There is certainly a calling for the development of a new, condensed version of this instrument, made simpler for very young children to understand.

Investigation in to the relationship between parent/child relationships and therapy outcome measures was limited due to both small participant numbers and the lack of a comprehensive measure that would provide a more suitable profile of parent/child relationships. The relationship between a parent and their child throughout a conflictual separation would certainly be complex and multi-faceted and would unlikely be best summarised by one single question pertaining to overall ‘happiness.’ It can therefore only be concluded that parents across both conditions, who rated their relationship with their child as high on a measure of happiness, were likely to have children with fewer externalising behaviour problems. This relationship only approached significance.

Benefit would be gained from making a comprehensive assessment of other services and medications accessed by participants during the testing phase. It is possible that other support services or medications could have had an unwanted effect on the results of the current study.

Overall, while the current study had limitations, it was a small pilot study, conducted as a preliminary investigation in to otherwise previously unexplored terrain. Despite limitations, the study provided strong evidence for the suitability of CBT for treating fear symptoms following a conflictual parental separation, and allowed for a valuable insight into how future programs may be improved upon.

6.6. Implications for Future Research.

Future research examining the efficacy of CBT programs for children showing fear reactions following a conflictual parental separation, would benefit from utilising larger group numbers. This would allow for more confident conclusions to be drawn. In addition, assessment measures need to be carefully chosen based on age and ability. The CPSS and CPICS were found to be difficult to administer to such young children. More suitable measures must be sourced in the future.

Parental conflict can refer to any number of forms of conflict, ranging from the milder form of witnessing a verbal argument, to the more severe form of a child actually being caught up in a

violent physical confrontation between their parents. The resulting effects of these two forms of parental conflict on a child could be vastly different, and this was not controlled for in the current study. There is a call for a comprehensive child questionnaire to be developed that detects all possible forms of conflict exposure. This would not only assist therapists in providing relevant and effective therapy, but would allow for a more controlled study to be carried out. For example, a study might benefit from including only those children who have witnessed a particular degree of conflict. This would strengthen findings and allow for more confidence in resultant therapeutic recommendations.

In order to control for child response bias, it may be useful to have a child's teacher complete a measure such as the CBCL, as well as the parent. Teacher ratings provide information on how the child is functioning when outside the family home. This can be valuable in understanding any social, attentional and rule breaking problems the child may have. This information can be further incorporated in to treatment, and allows for a much higher degree of confidence that the child is receiving treatment for all relevant behavioural problems.

In order to control for bias due to recurrent parental conflict, future research could utilise children who no longer have contact with one parent. Such examples include when one parent is absent due to having moved overseas, a restraining order, imprisonment, or death. This may control for the impact of future conflict on the child, however, the sample would not be representative of the majority of children who require therapy following a conflictual parental separation.

A study using a much larger sample would have adequate power to allow for the comparison of those who had a new episode of parental conflict to those who did not. This would allow for a greater understanding of the impact of recurrent parental conflict, and more confidence in interpretation of findings. The small sample size of the current study resulted in limited exploration of this variable.

Given that there is likely very little we can do to reduce parental conflict following separation, there may be great value in taking a more preventative approach with children who are going through a conflictual parental separation. There is a need for the development and testing of a

resilience training program with a focus on increasing self coping skills in the event of new conflict.

Benefit may be found in the inclusion of ongoing symptom monitoring post-therapy, as well as regular therapist/patient contact following parental separation. This way, if further conflict does occur the therapist will be aware and can offer further treatment if required. It may also provide some comfort to the child involved to know that their therapist is kept up to date with their progress. Therapist contact and ongoing symptom monitoring may be gradually decreased over time and perhaps replaced by monthly phone calls between the therapist and parent, and then eventually ceased altogether at a time deemed appropriate by the therapist. Given the often recurrent nature of parental conflict for several years post-separation, maintenance of therapeutic contact might be necessary.

In several instances past research has declined the use of a wait list control groups based on ethical reasons (Cohen & Mannarino, 1996, 1998a, 1998b; Deblinger, Lippmann & Steer, 1996; Deblinger, Steer & Lippmann, 1999). This is concerning given that a high number of children are likely to have a natural recovery during the weeks following trauma (Smith et. al., 2007). Without utilising a wait list control group, the degree of tendency towards natural recovery cannot be measured and factored into resultant analyses. It is therefore difficult to determine the extent that treatment or natural recovery, have contributed to results. Future studies could perhaps utilise a four week symptom monitoring period before treatment commencement, in order to be sure that the children being treated do in fact have persistent PTSD symptoms. This would allow for a higher degree of confidence that recovery is due to therapy rather than natural recovery mechanisms.

In order for a more comprehensive study of the influence of parent/child relationships on child adjustment throughout separation to be carried out, better assessments will be required. The relationship of a parent to their child throughout a parental separation would be no doubt complex and multi-dimensional. Examination of each of these dimensions in relation to therapy outcomes will be vital in the quest to determine exactly what elements of parent/child relationships, promote resilience and recovery. Identification of such elements would likely shape the content of future CBT programs and may also result in improved therapy outcomes.

Children who undergo early stress or trauma have a tendency toward neural abnormalities (Cicchitti & Curtis, 2005) as well as behavioural abnormalities in facial emotion recognition (Pollack, Cicchetti, Klorman & Brumaghim, 1997; Pollack, et. al., 2001). Prior research by the author (Cook, et. al., 2009) indicated that young adults, who reported a childhood trauma, had a significantly different neural layout than their non-traumatised counterparts. It was suggested that this lasting neural impact may be related to the increased tendency for adults with mental illness to report the occurrence of a childhood trauma. Such neural differences might also be related to the abnormalities in emotional facial recognition reported during childhood in traumatised children. It is unknown whether psychological therapies such as CBT, may allow for reversal of these neural and behavioural abnormalities. This is an area that requires extensive research, and may be best explored using a combination of EEG coherence measures, PFI testing, and CBT treatment.

While several studies have examined the neural impact of early trauma, very few have specifically examined the impact of parental separation. One study demonstrated that adults, who had been separated from one parent due to divorce during childhood, had significant long term alterations in Hypothalamic-Pituitary-Adrenal (HPA) axis functioning (Bloch et. al., 2007). Alterations in HPA axis functioning can result in unusual amounts of corticosteroid release. Traumatised children have been shown to have altered HPA axis functioning (De Bellis, et. al., 1994; Hart, et. al., 1995) and it is thought that this can be severely detrimental to the developing brain (Gunnar, 1998).

These past findings indicate that early traumatic events can have a lasting neurological impact in to adulthood. While we know that with therapy a child's psychological symptoms are often successfully ameliorated, we do not know whether this recovery is also apparent on a neurological level. That is, if psychological symptoms following trauma are treated, can the developing brain 'catch-up' or recover from any damage caused by HPA axis dysregulation? This would be a compelling area for future research to not only examine the efficacy of CBT programs for traumatised children, but to also examine whether better neurological outcomes might also be achieved for these children, both in the short and long term.

6.7. Conclusions.

In summary, a manualised 7-week Trauma-Focused Cognitive Behavioural Program was found to be an effective treatment for child fear reactions following a conflictual parental separation. Recurrent parental conflict was found to be a large bias on results, indicating that there is a need for these children to have either ongoing contact with their therapist, or for some form of resilience training program to be developed and tested for use by such children. In addition, the CBT condition was found to be a more effective treatment for fear reactions following conflictual parental separation, than a Bibliotherapy condition. The Bibliotherapy condition did aid parents in the reduction of ongoing parental conflict, and was well received by parents; however, it was not capable of reducing child pathological symptoms of PTSD or anxiety.

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Appendices.

Appendix A: Child Treatment Manual.

Note: The numbered Appendices referred to in this manual refer not to the Appendices within this thesis, but to the Appendices that occur at the end of the manual.

CBT Treatment Manual for Children

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2006

Treatment Protocol

Week	Session	Duration	Protocol
	Screen		Screening Instrument (phone)
	Intake Assessment	60-90 mins	Introduction to the program and Intake Assessment Battery (to be completed with treating therapist)
1	Combined Parent & Child Session 1 (No child group)	60 mins	<p><u>Engagement</u></p> <p><i>Parent & Child</i></p> <ul style="list-style-type: none"> • Introduce self and get to know the parent & child better • Discuss the program and how it will work • Identify the most problematic behaviour (trauma-related) in the child • Set up a reward system for child engaging in more adaptive behaviour <p><i>Parent alone</i></p> <ul style="list-style-type: none"> • Clarify that the child is the focus of the program • Affirm importance of parent's role • Involving the other parent • Answer any questions <p><i>Child alone</i></p> <ul style="list-style-type: none"> • The magic wand: what does the child hope could be different in their life (goal setting)? • Answer any questions • Measuring distress <p><i>Parent & Child</i></p> <ul style="list-style-type: none"> • Setting up a regular time for homework to be done
2	Individual Session 2 (Child group: kids to meet one another; do up posters to decorate rooms; suggest games/activities)	60 mins	<p><u>Identifying feelings & 'Stinking Thinking'</u></p> <ul style="list-style-type: none"> • Feelings: What are they, how to identify them, how they link to thoughts • Introduce child to 'stinking thinking', how to identify it • Assisting child to identify their own 'stinking thinking'
3	Group Session 1	60-90 mins	<p><u>Why has this happened to me & how can I feel better?</u></p> <ul style="list-style-type: none"> • Establish group rules • Children share their experiences of parental separation • Children share their strategies to cope with unpleasant feelings • Unpleasant feelings – what are they and how do we recognise them • SIT training - Diaphragmatic breathing ('calm breathing') - Progressive muscle relaxation ('muscle relaxing')
4	Individual Session 3 (Child group: More	60 mins	<p><u>Graded Imaginal Exposure</u></p> <ul style="list-style-type: none"> • Review SIT • Exposure – child is assisted to tell their story,

	on Stinking Thinking 1)		and to repeat it throughout the session <ul style="list-style-type: none"> • <i>Small group session</i>: Introduce discussion of stinking thinking scenarios, discuss scenario 1
5	Individual Session 4 (<i>Child group</i> : More on Stinking Thinking 2)	60 mins	<u>Exposure with challenging</u> <ul style="list-style-type: none"> • Exposure – child continues to tell their story, with increasing detail • Identification of child’s own ‘stinking thinking’, with appropriate challenging • <i>Small group session</i>: Discuss Stinking Thinking scenarios 2 & 3
6	Individual Session 5 (<i>Child group</i> : More on Stinking Thinking 3)	60 mins	<u>Exposure with challenging and future planning</u> <ul style="list-style-type: none"> • Exposure – child continues to tell their story, with increasing detail • More on child’s own ‘stinking thinking’, with appropriate challenging • Planning for future stressful situations (i.e. parental conflict at handover) • <i>Small group session</i>: Discuss Stinking Thinking scenario 4, kids’ own examples, and challenging their stinking thinking
7	Combined Parent & Child Session 2 Post-Treatment Assessment	60-90 mins	<u>Moving on.</u> <i>Parent & Child</i> <ul style="list-style-type: none"> • Review of the problematic behaviour – how it has progressed • Parent & child share what they have learnt, what has changed and how? • What did they like and dislike? • What was useful and what was not? • Discussion about future planning <i>Parent Alone</i> <ul style="list-style-type: none"> • More elaborate review of child’s and parent’s programs in the child’s absence. <i>Child Alone</i> <ul style="list-style-type: none"> • Further comments from child in parent’s absence (where applicable). <i>Assessment Battery</i> <ul style="list-style-type: none"> • Assist child to complete post-treatment assessment package. (To be administered by a different therapist where possible).
	3-month Follow-up Assessment	60-90 mins	Assessment Battery (to be administered by a different therapist)

Week 1 Combined Parent & Child Session 1

Engagement

The goal of this session is to engage the parent and child (will be built upon in subsequent weeks), and provide them with more specific information on the programme and what they will be doing. Parents will have the opportunity to identify a specific problematic behaviour (trauma-related) they have observed in their child, and to devise a plan to encourage the child to respond more adaptively to the stressor (reward system). Time will be spent alone with the parent to clarify the focus and purpose of the treatment programme. Time will also be spent alone with the child to explore with them what they would like to be different in their life and how the programme might work towards their goal. The concept of SUDS measurement will be introduced.

Outline

Parent & Child

- ◆ Introduce self and get to know the parent & child better
- ◆ Discuss confidentiality issues
- ◆ Discuss the programme and how it will work
- ◆ Identify the most problematic behaviour (trauma-related) in the child
- ◆ Set up a reward system for child engaging in more adaptive behaviour

Parent alone

- ◆ Clarify the focus of the programme: the child
- ◆ Affirm the role of the parent as ‘co-therapist’
- ◆ Involving the other parent
- ◆ Answer any questions

Child alone

- ◆ Get to know the child better
- ◆ The magic wand (goal setting): what does the child hope could be different in their life?
- ◆ Answer any questions
- ◆ Introduce the SUDS rating scales

Parent & Child

- ◆ Setting up a regular time for homework to be done
- ◆ Activity for home

Materials

- ◆ A magic wand
- ◆ Weekly SUDS scale (Appendix 1)
- ◆ Bear cards (therapeutic tool only; not for assessment)
- ◆ Drawing paper and a range of textas/pencils/crayons
- ◆ Some toys/puppets
- ◆ 4 handouts: “My Gold Stars Chart” (6 copies—1 per week), “My Rewards List” (2 copies), some gold stickers, Child and Parent Session Summary sheets

- ◆ CEQ and envelope (with ID labelled)—for parent to complete when therapist is alone with child

Therapist Guidelines

Parent & child

Introduction

It will be of paramount importance to ensure that the language used is understood by the child. Language should thus be simple, and the therapist should check in with the child that they have understood what has been said.

The therapist should be mindful that the parent and child will have uncertainties around attending. One of the goals of this session is to introduce yourself as a competent professional in the field, so that both parent and child feel that they are able to trust you and what you say to them. It is important to do this in a manner that is not threatening or overwhelming to the parent or child.

Discuss confidentiality early on in the session. It is important that each party understands that whilst what is said in sessions is confidential, there are professional limits to confidentiality. For example, when there is a perceived threat to someone's safety, the therapist will have to tell someone about the danger. Children may feel protective of their parents, and avoid talking about things that distress them in sessions if they think that their parents will find out what they have said. It is useful to establish with both parties that whilst the child is underage, a degree of confidentiality will be helpful in therapy. Explain to the parent that the child's safety is your top priority, so if the child is in danger, you may or may not inform them first before reporting the danger to appropriate authorities.

The therapist should use their own knowledge of the programme to describe what they will be required to do and how sessions will look. This will demystify the programme somewhat for the child, and reduce some of the anxiety around attending. Include in your description of the programme: what you and the child will be doing together, what their parent/s will be doing, and why. Incorporate that the child will meet with you a number of times, and that you will talk about what happened between mum & dad, and how the child feels about it. That the child would also meet some other kids who have had similar experiences, and that together we will talk about feelings, and what unpleasant feelings like being scared and worried feel like. We will also learn some ways to make ourselves feel better when we feel worried or scared. We will talk about something called 'stinking thinking' as well—they are the thoughts that make us feel bad. We will talk about ways to beat stinking thinking. Mum and/or dad will be coming to their own sessions too, and they will be talking about how parents fighting can make kids feel scared and worried, and how they can help you to feel better about what has happened. They will also be talking about some ways that they can help themselves feel better. You, your parent(s) and I are all working together to help you get rid of some terrible thoughts and feelings that you have been having, so that you can start feeling better again. Remember, we are not here to get mum and dad back together again. We are here to help you get better.

Questions should be invited, and answered honestly and clearly.

Identifying the problematic trauma-related behaviour¹

Parents are likely to have become interested in being involved in the programme because they noticed symptoms of trauma-related anxiety in their child. In this first session encourage the parent to identify what behaviours or changes in their child are concerning for them². Some of these are not likely to improve without advances made by the parent in their group work³; however there will be some where the child could be encouraged to adopt a more adaptive behaviour. The point here is not to just focus on the problem behaviour, but to talk about how gradual changes/improvements in the target behaviour can be rewarded and positively reinforced.

An example could be that the child tends to misbehave when returning from a stay with the other parent. Whilst this behaviour is likely to be the result of anxiety and difficulty adapting, the child could be encouraged to behave in a more cooperative manner. Together with the parent and child, brainstorm alternatives to misbehaviour, and each time the child engages in this desired behaviour, offer two rewards: an immediate one (such as positive attention, and praising the child for the good behaviour); and a longer term one that involves a point/award system (using gold stars). The point system involves winning points for positive behaviours that parent and child agree on—different behaviours can earn a different number of points, and bonus points can also be awarded, e.g. if for 3 consecutive days the child maintains the good behaviour. These points can be accumulated over time and later cashed in for a ‘larger’ reward, E.g., when 5 points are reached the child gets an ice-cream, or after 10 points the child is allowed to choose a movie to go to with the parent. Make sure that the target behaviour (at least for the first week) is easily achievable – it is important that the child successfully gets their reward in the first week, to keep them engaged in this whole initiative.

GIVE PARENTS the “My Gold Stars Chart”, “My Rewards List” and some gold stickers (WEEK 1 PARENT HANDOUT 1 AND 2), and let both parent and child sign the rewards list. It is a good idea to keep the rewards as family focused as possible, so that on top of the reward the family is spending good times together. Check up on the child’s progress each week, and change the behaviour being targeted as required.

Emphasise that the most effective way to change bad behaviour is to encourage good behaviour (as alternatives). Explain to parents that simply discouraging or punishing bad behaviour tends to make children well behaved but depressed.

It is of critical importance to be sensitive to the child's age and developmental level throughout each step of this treatment programme. All information provided needs to be geared to the child’s level of understanding. Younger children may prefer drawing and role play, whereas older children may prefer to write or communicate verbally. These decisions need to be made by the therapist.

¹ If the behaviour mentioned is nightmares or related sleep disturbances, refer to Child Manual Appendix 7: Trauma and Sleep. Briefly go through this optional resource with the parent and child, and give the parent the related handout for future reference. Proceed to then ask for another problem behaviour.

² Often parents don’t or can’t identify problems with their children because they are focused on their own stress in regards to separation. In many cases the therapist will need to inform the parent.

³ It might be that the parents are the ones who need to change their behaviour, e.g., stop arguing at changeover. The parent group sessions will cover this and related issues that are targeted at reducing the child’s further exposure to parental conflict, which is the likely cause of the child’s symptoms in the first place.

Parent Alone

Clarify that the focus of the programme is the child: to reduce the child's trauma/fear symptoms both *directly* through the treatment and *indirectly* through reducing the child's exposure to future parental conflict (parenting and communication skills training). Affirm the role of the parent as *co-therapist*, in supporting the child throughout the treatment process and reinforcing the skills the child learns during the programme, at home. This involves the parent diligently completing their own homework, as well as assisting the child to complete theirs. Emphasise that the parent's efforts to improve their own relationship with their child, and their co-parenting and communication skills with their child's other parent, will have significant payoffs for their child and themselves. Note to the parent that if possible (and safe), the other parent is encouraged to take part in the parent group programme as well, but will be allocated to a different group. Request for the contact details of the other parent (if not already provided). Answer any other questions the parent may have.

Next, the therapist will see the child alone. Hand the Credibility/Expectancy Questionnaire (CEQ) to the parent to complete while waiting. The CEQ is a measure of the parent's expectation of how effective and helpful the treatment offered to the child will be in reducing the child's symptoms. Ask the parent to seal the completed questionnaire in the envelope provided and return to the therapist when they get back together again before ending the session.

Child Alone

Get to know the child better (e.g. have the child draw a picture of their family and/or tell you about each family member, what they like to do, their hobbies etc).

If the child is non-responsive, continue to be warm and engaging. Ask them if they feel like drawing or playing with the puppets or toys, or using the bear cards (e.g. pick out cards to describe each family member) instead of talking. Usually younger children are not good with verbalising their thoughts and feelings, and are thus reluctant to talk. However, these children would usually respond to the opportunity to tell their *story* using toys and drawings. The therapist can also encourage the child to engage in the activity by starting to do it, drawing/playing with the toys and expressing to the child how enjoyable the activity is.

The magic wand activity

The idea of this activity is to give the child a wand to hold, and ask them to imagine how they would change things in their family if they were granted three wishes. You want to elicit from the child their wish for how things could be different (~~it~~ can be anything"). The therapist can start off this activity by demonstrating it themselves (i.e., make a wish aloud, waving the wand). Make it fun. Some children may make a wish that is unrealistic, such as ~~that~~ "my mum & dad will get back together", or ~~that~~ "the fights between mum and dad never happened". Explore this wish with the child, why do they wish it, how they imagine things would be if their wish did come true. It is also important at this stage to check with the child how likely it is that their wish will come true, and to discuss with them other ways that things could be better. Explore these with the child, e.g., that mum and dad didn't fight as much etc. This can lead into providing a rationale for the programme, and what things we will be working on to improve. There is no need to discredit the child's wish by stating that it's unrealistic, but be careful not to reinforce or feed any assumption that we are there to make the (unrealistic) wish come true. It

is up to the therapist's discretion to decide whether the child is willing to talk more about their wish at this stage. There is no need to push them if they are not ready, but note down their wishes and be sure to follow up on them as appropriate in later sessions (e.g. in Exposure)..

Measuring distress

Introduce the SUDS rating scales, explain that we will be using them regularly and why, and get a rating of how the child has felt over the past week.

The purpose of the weekly SUDS rating is that the therapist will be able to determine the degree of anxiety associated with the child's 'worst' memory of the parental conflict and separation (the thought/memory generating the most fear in the child) from week to week. As improvements are made, feed these back to the child. The severity of the child's fear reaction following the psychoeducation and skills training components of the programme will determine how much time is spent in exposure-based work during the subsequent individual sessions.

The SUDS rating scales

—Since one of the things we will do together is talk about what happened between your mum and dad, we will need to work out how scared you feel about those memories at different times. So what I will do is sometimes show you this piece of paper (Appendix 1) and ask you to tell me how scared you feel. If you have a look, there is a list of numbers from 0 to 10. Down at number 0 is where you aren't scared at all, like how you feel when you are sitting cuddled up on the couch watching your favourite TV show. Up at number 10 is where you feel the most scared you have ever felt. Let's practise using it.

Imagine you have just been tucked up in bed, and you are feeling sleepy. The house is quiet, and everybody else is comfortably in bed. Can you imagine that feeling? How scared do you feel then, on this scale from 0 - 10? Can you point to/tell me the number?

Ask the child what was the most scary time they remember about mom and dad's separation/fighting - it may not be the same as what the parent thinks. If the child doesn't want to describe the event to you, that is ok, but ask them to keep the memory clearly in their mind when they answer the next question.

If I asked you to think about _____ (above event- fighting between parents, a specific incident—whatever the child reports being most fearful of) right now, to imagine you are there and it is happening, how scared do you feel (now) on a scale of 0-10 (where 0 = not scared at all, and 10 = the most scared you have ever been)?"

Use this activity to help orient the child to the rating scale where appropriate, e.g. —What might be a situation where you felt about a 5?"

Parent & Child

Before introducing the homework for this week, explain to the parent and child the role of homework (to practise, apply, and help them remember what they have learned) and that it is of critical importance to the success of the programme. Explain that parents will be required to go over each session with the child at home, with the child describing what they learned using

their outline. Parents will also receive an outline so that they understand what their child is doing. Parents will be required to support the child in practising the skills they learn each week.

Facilitate the setting up of a regular time when the parent and child can sit down together at home to discuss what the child did in their session—this will reduce the chance that the parent will run out of time or forget.

Activity for home

*GIVE PARENT AND CHILD **Session Summary** sheets.*

In reward for coming along to the session, the activity this week is for the parent and child to treat themselves to something special. The treat for the child should be something small like a chocolate bar, extra time on the computer etc. Make a list of weekly special treats that the child could have each week after they attend their session.

The parent's homework is to make sure this happens- even if the child behaves badly in some other way, they must get a reward for going to the session. In addition, parents are to put into action the rewards system for good behaviour.

Emphasise that parents must give themselves a reward as well - tie them down to a day and a time in the coming week and ask exactly what their treat will be. Inform the parent that their group therapists will check if they did this next week.

Week 2

Individual Session 2

Feelings Identification & an Introduction to ‘Stinking Thinking’

The goal of this session is to introduce discussion about feelings (in particular unpleasant feelings such as worry and fear), to make the connection between thoughts and feelings, and to discuss ‘stinking thinking’. It is hoped that children will be able to start identifying their own ‘stinking thinking’, and how it influences the way they feel.

Outline

- ◆ Weekly SUDS rating
- ◆ Weekly review of progress re: problematic behaviour identified in week 1
- ◆ Review of last week’s session & home activity
- ◆ Feelings: What are they, how to identify them (using bear cards), how they link to thoughts (using scenarios)
- ◆ Introduce child to negative or ‘stinking’ thinking
- ◆ Assist child to identify their own ‘stinking thinking’
- ◆ Activity for home

Materials

- ◆ SUDS scale
- ◆ Bear cards (as therapeutic tool)
- ◆ ‘Feelings’ worksheet (Appendix 2)
- ◆ Drawing paper and a range of textas/pencils/crayons
- ◆ 3 handouts: ‘Thoughts and Feelings’ scenarios, ‘Stinking Thinking’ worksheet, and Child Session Summary

Therapist Guidelines

Weekly SUDS rating

Depending on the age/developmental level of the child

–If I asked you to think about _____ (fighting between parents, a specific incident—whatever the child reports being most fearful of) right now, to imagine you are there and it is happening, how scared do you feel on a scale of 0-10 (where 0 = not scared at all, and 10 = the most scared you have ever been).”

Weekly review of progress and homework

Ask the child if they got a small treat for attending last week’s session. Ask them if they enjoyed it. Also ask if they managed to achieve a reward on their rewards chart for improving their behaviour as discussed in last week’s session. Congratulate them if they did. If they didn’t achieve one, ask them how they feel about it. Was it too hard? Did they try? Did their parent overlook or forget to reward their good behaviour? Encourage the child to keep working at improving their behaviour. After the session, speak to the parent or give them a call to find out why and perhaps modify expectations of target behaviour to make it easier for the child to achieve.

Introduction to feelings

—The reason we are talking about what feelings are and what they feel like in our bodies, is that we will be talking a lot about your feelings over the next few weeks. It will be easier to talk about feelings if you know what they are and what they feel like.”

The important message to convey is that feelings are normal. We have all sorts of feelings, like happiness, sadness and anger, and whilst some feelings are not very nice to have, they do have a purpose. Feelings are our body’s way of telling us something about the situation we are in.

A useful activity would be to spread the bear cards out and have the child identify (choose one) how they are feeling now. How they felt last week before coming into the session? How they might feel if they won a competition? How they might feel if they had fallen over and hurt themselves at school? How they might feel just before a race or a test at school? You could also ask the child to pick a card from the pack, and tell you what the feeling might be, how they can tell, and a time when they felt that way. The therapist could also take turns with this activity. The focus should be on identifying the feeling, how it feels in the body, and when you might feel that way.

How feelings link to thoughts

It may be useful to present to the child some scenarios that illustrate how the way we think influences how we feel, before discussing this connection. It will be easier for the child to understand the connection by experiencing it first-hand.

Show child the **—Thoughts and Feelings scenarios**” (Appendix 2; 3 pages)—Ask the child to fill in the appropriate facial expression for the person in each scenario.

—As you can see, how we think affects how we feel. If we think the worst, we feel bad. We call this stinking thinking, because the thoughts often aren’t right, but they make us feel bad anyway. Why don’t I list some thoughts, and you can tell me if it is stinking thinking or good thinking.”

Warm up gradually to the statements about parents fighting. Start with more general statements that the child can easily relate to (e.g, interests, sports, pets)

- ◆ ~~It~~ is my fault that my soccer team lost because I missed my shot at goal” (alternative: ~~I~~ made a good shot, but the goal keeper did a great catch”)
- ◆ ~~It~~’s all my fault that my puppy chewed up Mom’s new shoes” (alternative: the puppy is little and very naughty, needs to be trained, etc)

As the child warms up to the activity, direct the discussion towards thoughts that are more relevant to parental separation/conflict:

- ◆ ~~It~~ is all my fault when my parents fight”
- ◆ ~~It~~ is not my job to make my parents get along”
- ◆ ~~It~~ is all my fault that my parents separated”

Do you have any stinking thinking? Explore this with the child. If child finds this hard, get them to tell their story and explore their stinking thinking that way. Again, use drawings, bear

cards and toys as desired to help engage the child. E.g., which bear looks like Mom when mom and dad are fighting? Which one do you look like when that happens? What are you thinking when you look like that? Or pick out a certain card and ask, “if dad looks like that, how do you feel? What are you thinking when you feel like that?”

Empathise with the child’s thoughts and feelings. Identify with them, and let them know that in the coming weeks we are going to learn ways to get rid of these yucky thoughts and feelings so that they can feel better again.

What might be some examples of good thinking?

Activity for home

GIVE CHILD HANDOUTS –Stinking Thinking” and Child Session Summary.

To sit down with the parent who is also attending the programme, and tell them what they did in the session today, using the outline handout as a guide.

Also, to be on the lookout for ‘stinking thinking’ – when a thought makes you feel bad, write it down in the worksheet provided (if they are old enough to do so), or draw a picture of what happened/what you were thinking/feeling and we can talk about what the pictures mean next week (see Appendix 3). Bring the worksheet with you to next week’s session and we will talk about your examples then.

Week 3

Group Session 1

Unpleasant Feelings & How I Can Feel Better

In this session the children will hear each other's experiences of parental separation, and share ideas about how they cope with the unpleasant feelings associated with their memories and current experiences. Together the children will work through which strategies are useful and which are less so. They will be taught some positive strategies (stress inoculation techniques) as a group. The goal of the session is for children to feel less alone in their experience.

Outline

- ◆ Introductions
- ◆ SUDS rating
- ◆ Weekly review of progress re: problematic behaviour
- ◆ Warm-up game (see Appendix 4)
- ◆ Rules for the group & confidentiality
- ◆ Review of home activity (review session with parent and stinking thinking worksheet)
- ◆ Children share their experiences of parental separation, led by the group leaders
- ◆ Unpleasant feelings – what are they and how do we recognise them
- ◆ Review –Stinking Thinking” examples from last week’s worksheet
- ◆ Children share their strategies to cope with unpleasant feelings
- ◆ SIT training – ‘My toolkit’
 - Diaphragmatic or ‘calm’ breathing
 - Progressive muscle relaxation
- ◆ Handout cards for SIT
- ◆ Activity for home

Materials

- ◆ SUDS scale
- ◆ Bear cards (as therapeutic tool)
- ◆ Sticky labels (for name tags)
- ◆ Materials for warm-up game
- ◆ Butcher paper and thick textas or a whiteboard with textas
- ◆ Drawing paper and a range of textas/pencils/crayons
- ◆ 2 handouts: SIT pocket card and Child Session Summary
- ◆ 2 worksheets: –Breathing Log” and –Relaxation Training”

Therapist Guidelines

Therapists should do this individually with each child (privately as far as possible) at the beginning of the session and note down the child's response on the sheet attached to the inside cover of the child's folder:

Weekly SUDS rating

–If I asked you to think about _____ (fighting between parents, a specific incident—whatever the child reports being most fearful of) right now, to imagine you are there and it is

happening, how scared do you feel on a scale of 0-10 (where 0 = not scared at all, and 10 = the most scared you have ever been).”

Have the children write their names on a name tag for each session. Start by playing some introduction games (see Appendix 4 for examples), to break the ice and help the kids to relax before divulging information about their experience of family violence/conflict/separation.

Rules for the group (get kids to collaborate on this)

Communicate the importance of all the members of the group feeling comfortable. That together we will put the list together, and hang it on the wall to remind us of the rules. Write down the rules on some butcher paper, incorporate suggestions from the kids—use their language where appropriate. Each week hang this list up on the wall (in the group room). Incorporate the rules that everybody has a chance to speak without being interrupted, treat others as you would like to be treated, and what is said in the group stays in the group.

Confidentiality

Stress that what the children say in the group will remain in the group. We want to encourage free expression and trust. However also state that if one of the group members is in danger, then the leaders might have to break the confidentiality rule to keep that group member safe. Safety needs to be the first priority.

Children share their experiences of parental separation

Be direct in asking the group questions, so that they know that they are all in a similar position, and it is clear what they are being asked. E.g. “How long has it been since your parents separated? Have things got better or worse since they separated?” Let’s make a list of what things are better, and what things are worse (use whiteboard).

Unpleasant feelings – what are they and how do we recognise them?

Ask children to call out the feelings they know, and say whether they are a good or a bad feeling (categorise them). This list can be hung on the wall to remind the children of the different feelings. Add to the list if the group doesn’t come up with some of the key feelings.

Work through some of the core feelings, making sure to include among them the unpleasant affective states such as *sad*, *worried*, *angry*, and *scared*.

For each feeling ask—“How can you tell when you are feeling _____? What does your body feel like? How do you act?”

Review —“Stinking Thinking” examples from last week

Ask children to refer to the worksheet from last week on which they had noted down their stinking thinking in the past week. Go around the group and ask children to share their examples of stinking thinking and how those thoughts made them feel.

Children share coping strategies

Ask the children: “When you’re feeling bad about what happened between your parents, what do you do?”

Write a list of the different coping strategies on the board, and then ask the children to categorise them into good ways of feeling better or bad ways. Use this to introduce two good ways they can help themselves feel better when they have stinking thinking and are feeling nervous or anxious.

SIT training – ‘My Toolkit’

When teaching new skills it is important to offer a rationale for the skill, demonstrate it, have the child demonstrate it back, and have the child practise the skill at home.

Diaphragmatic or ‘calm’ breathing

The rationale offered to the child should include:

- ◆ Whilst we breathe all day every day, this is a special type of breathing. You could call it ‘calm breathing’.
- ◆ It allows us to calm down, and get some control over the bad feelings.
- ◆ It is something that we can do anywhere at any time, and we can do it on our own.

–This type of breathing is different to normal breathing. Let me show you how it goes. When I breathe in, I start the breath from right down in my tummy, and I breathe in slowly. Like this. (With your hand on your stomach, give an example of a slow, diaphragmatic intake of breath). Then you let the breath out *very* slowly, like this. You need to make sure that your breaths start from way down in your stomach, not from up here in your chest.

Now let’s all try together. Put your hand on your stomach so you can feel it move, and slowly breathe in, then *breathe out even more slowly* (do this at least 10 times). You can imagine you are breathing in good thoughts with the clean air, and breathing out your worries. You can try saying slowly to yourself the word ‘calm’ as you breathe out. Do you feel any changes in your body?

I want you to practise this breathing everyday. You can choose when, but make it a time when you can concentrate, like just before bed. I want you to practise taking 20 deep breaths each time.”

Progressive muscle relaxation

This is a progressive muscle relaxation script designed specifically to appeal to children, and the scenarios explained are easier to recall so the child can practice the technique at home/school. You could call it ‘tighten & relax’. This script starts with the legs and feet as one muscle group, moves up to the shoulders and upper body as another muscle group, then to the arms and hands, finishing with the face. Using fewer muscle groups will make it easier for the child to recall the exercise. Speak in a relaxed and calming manner whilst reading the script.

The rationale offered to the child should include:

–When we are worried or stressed our muscles can feel tight and sore. When we relax our muscles, we feel calmer and more comfortable.”

This exercise is one where we tighten different parts of our body, then relax our muscles. I will talk you through it. Sit back in your chair and get as comfortable as you can, put both

feet flat on the ground and let your arms hang loose by your sides. Now close your eyes, and don't open them until I say so.

Pretend you are in a big barrel full of grapes, and you are squashing the grapes with your feet to get the juice out. It is hard work; you will need to use your legs to help you push down. Feel the grapes under your feet and between your toes, squash, squash, squash as hard as you can. Now relax your feet, let your ankles and toes go loose. They feel all nice and relaxed. Now back to the grapes, squashing down, down, down through your feet. Let's get all of that juice out. And relax again. Feel your toes, feet and legs relax. They don't feel stiff at all.

Now pretend that you are standing under a big tree, and you are reaching up with both arms, trying to get your ball which is stuck in the branches. Stretch up high with both arms, as high as you can, you can nearly touch the ball. Then drop them to your sides. Can you feel your shoulder muscles relax? Ok, let's give this another go, the ball is nearly within your reach. Lift both of your arms high over your head, stretch, stretch, stretch—you have almost touched the ball. Stretch just a little bit further. Then drop them to your sides again, and feel the muscles loosen and relax.

Now pretend that you have a big orange in each of your hands. You need to squeeze both hands very tight, you are trying to squeeze all of the juice out of these oranges. Can you feel the tightness in your hands and arms as you squeeze? Now drop the oranges to the floor, and feel your muscles relax. Grab two more oranges, one in each hand, and squeeze them even harder this time, we want every drop of juice out. Squeeze, squeeze, squeeze. Feel how tight your muscles are. Then drop the oranges to the ground, and feel your hands and arms relax.

Now let's pretend that there is a little beetle crawling on your face, but you can't swat it away with your hands. Try and get the beetle off your face without using your hands. Screw up your nose, and scrunch up your face. That's the way. Get that beetle off. Now relax your face and nose. Oh no, here he comes again. Wrinkle up your nose again, and scrunch up your face. Hold it as tight as you can. Scrunch, scrunch, scrunch. Can you feel your cheeks and forehead all tight? Now, relax your face and nose, let those muscles lose all of the tightness, your face smoothes out, and feel the rest of your body relax too. Now you can open your eyes.

If some kids (especially the younger ones) don't do well with this exercise, ask them to squeeze all their muscles really tight so that they form a ball with their whole body. Hold this position for a few seconds and then relax. Ask them to repeat this several times.

Now you know what it feels like to have tight muscles, and also what it feels like to have loose, relaxed muscles. Whenever you feel that you have tight muscles, like in your shoulders or face, you can do these exercises to relax them and help you be calm."

Activity for home

GIVE CHILD WORKSHEETS –Breathing Log” and –Relaxation Training”, and HANDOUTS –SIT card” and Child Session Summary.

To sit down with the parent who is also attending the programme, and tell them what they did in the session today, using the outline handout as a guide.

To practice the 2 skills learned today – calm breathing & relaxing our muscles. Refer the children the SIT cards (Appendix 5) which they can take home and use to practice. Also explain the purpose of the 2 worksheets, where the children are required to keep a log of the dates and times they practise these skills. Explain the instructions clearly to them. Work out some times with each child when it would best fit in to their day, e.g. just before bed or first thing in the morning. Parents are to be involved as well, to encourage the child and practise with them each day.

Week 4
Individual Session 3

Note to therapists:

Some kids may pick things up really quickly—it is OK to let them move ahead and do exposure sooner. On the other hand, some kids may never be ready for exposure at all. Keep this in mind for all sessions.

Graded Imaginal Exposure

In this session you will begin graded imaginal exposure with the child around the feared memories, with the goal that the child's fear reaction will habituate upon repetition of their story. The child will be encouraged to communicate their story through whichever means are appropriate, with prompting from the therapist for greater detail as the child becomes less fearful of the memories. There will be no challenging of thoughts during this session; it is exposure only.

Outline

- ◆ Weekly SUDS rating
- ◆ Weekly review of progress re: problematic behaviour
- ◆ Review of last week's session & home activity – practise SIT and keep a log of it.
- ◆ Discuss the rationale for exposure with the child in appropriate language
- ◆ Exposure (40 mins)—assist child to tell their story (write/draw/act out), and to retell the story in increasingly greater detail, paying attention to feelings and thoughts experienced at different points. *Therapist will need to pay attention to parts of the story that are especially difficult for the child, to focus on in subsequent exposure sessions.*
- ◆ *Note: NO cognitive challenging at this point.*
- ◆ Relaxation
- ◆ Activity for home

Materials

- ◆ SUDS scale
- ◆ Bear cards (as therapeutic tool)
- ◆ Drawing paper, lined paper and a range of textas/pencils/crayons/pens
- ◆ Some decorations such as glitter, ribbons etc.
- ◆ A stapler
- ◆ Some toys/puppets for the child to use in telling their story
- ◆ Handout: Child Session Summary

Therapist Guidelines

Weekly SUDS rating

–If I asked you to think about _____ (fighting between parents, a specific incident—whatever the child reports being most fearful of) right now, to imagine you are there and it is happening, how scared do you feel on a scale of 0-10 (where 0 = not scared at all, and 10 = the most scared you have ever been).”

Introduction to Exposure

Many children exposed to a traumatic experience will present with symptoms of fear/anxiety, particularly to reminders or memories of the trauma. If these symptoms do not decrease naturally, children may try to control these symptoms by using unhealthy patterns of avoidance. This can include avoiding contact with a parent. Avoidance can have a significant impact on the day-to-day functioning of the child, and when severe can impact upon the child's normal development.

An important step in the treatment of trauma-related fear reactions is to teach children ways of managing their fear that are more adaptive than avoidance. By exposing the child to the feared memories, they discover that they will not be overwhelmed by the memories and be unable to deal with them; in fact, they will gain practice in dealing with these intense emotions. Moreover, through exposure children are able to make attempts at understanding their experience and integrating it into their world view; their distorted cognitions are exposed and able to be challenged; and ultimately the child's level of anxiety (emotional and physiological) relating to the trauma naturally habituates with its retelling.

The idea of directly discussing the child's traumatic experience may seem counter therapeutic to some ways of thinking, however the goal of exposure is to break down the associations between a range of thoughts, reminders or discussions of the trauma on the one hand, and overwhelming negative emotions on the other. The child needs to understand that the reason for the exposure is that in confronting their fears, the fears will start to fade. Without this understanding, children are likely to feel overwhelmed during sessions and avoid the exposure. They will need to be reminded of this during sessions, and encouraged to 'stick with the thoughts' as it will get easier.

Two analogies are used here for the PTSD symptomatology and how we are going to treat it with prolonged imaginal exposure. Therapists can adapt and use these analogies where appropriate:

The Trauma Box Analogy

Very often, after a trauma we tend to pack away into a box the event and file away what happened, putting it to the back of our mind. We then use a little strength to keep the lid tightly closed and try to leave it undisturbed. However, over time, two things happen. Firstly our strength begins to wane and it becomes more of an effort to keep it sealed. Secondly, due to the pressure, the box begins to lose its shape, if you like, and small cracks begin to appear. What we experience as symptoms (e.g. re-living the trauma and having disturbed sleep) is like the content of the box spilling out through these cracks. This may scare us and we go on to avoid anything that reminds us of the trauma and try to stop thinking and talking through exactly what happened and how we felt. In this way the content of the box becomes a "ghost" which we have learned to fear.

What we will be doing during some of the therapy is to open the box and inspect the content for what it really is. In this way we can talk through what happened and how you felt. However, this will be done in a precise way so as to avoid as much suffering as possible. In this manner we will be inspecting the "ghosts" that have been created and throwing away any un-adaptive and distressing beliefs you may

have about the event. We find that once the trauma has been dealt with in this manner the symptoms become much less severe and less frequent.”

Digestion Analogy

–Sometimes we eat something which may cause us indigestion. It may lie in the bottom of our stomach and just weigh us down and we can prove it is still there by being sick. To get rid of the item we can either expel it or digest it. We cannot expel a trauma because we cannot take back what has happened, but we can digest it and ~~–integrate~~” it into who we are. It is thought that traumas that still cause problems later on, have not been integrated into the person’s self-concept and this should be one of the goals of the therapy. What we will be doing is to integrate the trauma into who we are so it no longer ~~–sticks out~~”. We will be doing this by progressively desensitising you to the memory and integrating the trauma. This process is sometimes referred to as HABITUATION.”

Some of the words in the above analogies (e.g. habituation) can become ~~–buzz~~” words during the therapy. However, it is important to pitch the rationales at the client’s level of understanding.

Two types of Exposure may be used with the children—therapists should use discretion in deciding which one to use, if either; and some children may do both types. Below is some additional information for therapists to refer to for a basic understanding of these two types of exposure treatments (as used for adults).

1) *Exposure in vivo*

Anxiety prediction and exposure anxiety hierarchy

Obtain an example of ~~–0~~” SUDS and put this at the bottom of the hierarchy (see Appendix 8). Ask them what a **safe** ~~–10~~” SUDS would be and put this at the top of the hierarchy. Then fill in the rest of the form. However, make sure that this *in vivo* exposure hierarchy has only situations that are safe to attempt (e.g. do not list walking in the park on their own in a high crime area as an item to be completed - get a companion, in this case, to accompany them). Emphasise the need for the client to remain in the situation for 30 to 45 minutes or until the SUDS decrease considerably, in line with the rationale already given.

Overall, it is important to make sure that:

- Client is instrumental at all stages of the development of, and therefore, ~~–owns~~” the process.
- None of the situations in the *in vivo* exposure hierarchy poses a real threat.
- Situations are related to the trauma, i.e. client not avoiding.
- Hierarchy is ~~–do-able~~” and not dependent upon unlikely scenarios.
- Begin at a level which is high enough to derive anxiety from the situation, but not so high as to let the client fail.
- Client has coping strategies (not necessary to use them, but increases sense of control and, therefore, compliance).

- Therapist reviews performance with client, reinforcing positives and problem solving difficulties.

2) Imaginal Exposure

During imaginal exposure the client will be asked to sit in a comfortable chair and will be given the following instructions:

–I'm going to ask you to recall the memories of the trauma (or representative trauma). I'll ask you to close your eyes so you won't be distracted. I will ask you to recall these painful memories as fully and as vividly as possible. I don't want you to tell a story in the third person, but to describe it in the present tense, as if it were happening now, right here. However, you are perfectly safe here (e.g. on a train). You will close your eyes and tell me in detail what you see and feel. We'll work together on this . If you start to feel too uncomfortable and want to run away or avoid it by leaving the image, I will help you stay with it. We will tape it so you can take the tape home and listen to it. Occasionally I'll ask you to rate your anxiety level on a scale from 0 to 10. Please answer quickly and don't leave the image.”

May need to normalise trauma situation first due to embarrassment’.

The procedure for prolonged imaginal exposure, as used by Dr. Edna Foa, is best followed. However, record the SUDS at the same point throughout the imaginal exposure from now on (preferably at the major hotspot’). During this first session only induce the memory of what the client is willing to stay with, although a minimum SUDS rating of between 5 and 7 should occur. Continue with this scene for approximately 60 minutes, until the SUDS have decreased and habituation has occurred. Don't forget to be empathetic and use encouraging and supportive comments.

As sessions go by, allow for more of the scenario to unfold (which may increase the anxiety) during the imaginal exposure.

Process Issues:

- Adopt a non-judgmental attitude.
- Display comfort with the topic area but sensitivity to client's feelings/reaction.
- Be confident in efficacy of treatment.
- Normalise client's response to the trauma.
- Keep in present tense.
- Emotional engagement necessary - Ask for feelings, emotions, thoughts
- Trauma should be repeated without leaving scene/emotions.
- May need to target ~~hotspots~~”.
- This is *not* a sadistic process, rather one that may be painful at points, but leads to healing.
- Client to have a sense of control during the process.
- Prompting & reinforcement during exposure.

Prompts

- You're doing really well, stay with it.
- I know this is difficult, but you're doing a great job.
- You are safe here.
- Feel safe and let go of the feelings.

Reinforcement

- Well done, it took courage to do that.
- See, you are much less anxious now when imagining the scene.
- See how staying with it meant your anxiety eventually dropped.

Common Problems:

- *Lack of trust in therapist.*
Address through discussing experience and what they think is necessary and why.
- *Dissociative tendencies (avoidance).*
Keep client grounded. May need to use sounds or touch arm (need to obtain permission first and the expectation that this will occur to help them stay grounded.)
- *Lack of affective involvement.*
Ask/prompt about situation (what is happening? Keep talking it through), feelings (What are you feeling? Where in your body?), emotions (Are you sad, frightened, angry?), and thoughts (What are you thinking/expecting at this point?).
- *Anxiety didn't drop.*
–You were anxious today during the exposure, but you did it. It will get easier each time. You were not sure you could do this but you have. You should give yourself a big pat on the back/chocolate/reward”.
- *Too much anxiety (client may feel overwhelmed/out of control).*
What is happening? Keep talking it through! You are safe here. This is a memory, not happening in reality. Train analogy!! May need to ground the client in present through appropriate touch but only after obtaining permission.

Make sure the client is not still aroused when leaving the session!!

The exposure exercise – the child tells their story

Prolonged, graded imaginal exposure (retelling the story in the *past tense* as opposed to the present tense in the first instance) will be used in this programme due to the young age of the clients and the nature of their traumatic experience.

Start by asking the child to draw/decorate the title page of their story. Spending some time reviewing that and adding some extra personal details (innocuous i.e., hobbies, pets) will be a good way to engage the child in the exercise and slowly work into discussing the traumatic experience. It is the therapist's decision as to how to proceed with the exposure exercise, and will depend largely on the memories to be discussed. Some children may be distressed predominantly by one event, and the therapist can approach the story by starting from the days before the event and work through to the distressing event and what happened afterwards. It is likely that due to the nature of the traumatic stressors amongst these children, several events

over time and what happened subsequently will be distressing to the child. In this instance, the therapist will need to determine a suitable starting point for discussing the events, and work through each sequentially so that together they make a single story.

In this first session of exposure, assist the child to tell the story from start to end. Ask the child to read or tell you what is happening in each part of the story after they have written/drawn it. Once the story has been completed, ask the child to read/look through their book, and to talk you through the story from start to end. Ask them also if there is anything important or really scary that is missing. If the child has omitted important details that you are aware of, prompt them for those details.

Encourage the child to describe what happened before, during and after the incident which generates the most distress for them (the incident of parental conflict which generates the traumatic symptoms). Allow them to talk about, write out, draw pictures of or act out using puppets/dolls (whichever is more developmentally appropriate, and whichever the child prefers), although more than likely it will be a combination of different methods. Encourage young kids to speak to a puppet if it helps them to verbalise their experience more comfortably. (*Cautionary note: Do not use a puppet to talk to the child or ask suggestive questions. Where puppets are used, let the child use them as they wish, without specific direction from the therapist*) Explain to the child that you want them to imagine the different parts of the incident in their heads, like a movie, and that you want them to talk about it in enough detail that you can imagine it as well. Ask the child to talk about the incident in first person, in the *past* tense. Only in the instance where the child's symptoms do not appear to be improving, or the child shows no emotional engagement with their story when they tell it in the past tense, then have them tell their story in the present tense. Stress that it is OK if they don't know how to spell something, that you will help them. With very young children who are drawing their story, the therapist can write down what the child said, and in subsequent sessions assist the child in describing what happened. If the child doesn't give much detail in their telling, prompt for more detail i.e. "Describe the room to me". If the child is drawing their story in pictures, make sure that you understand everything within the picture by asking questions about it. Keep them going in their story-telling from beginning to end, don't allow them to skip over any part or stick around a particular point (potential "hot spots").

Use reflective listening throughout the exposure. Keep the child engaged and involved in their story. Ask "Have I got this right?" and repeat their story to them, asking them to correct you if you are wrong. Prompt them: "How did you feel when this was happening? What were you thinking? How do you feel now? Do you still believe now that (what you feared) would happen?" Use lots of encouragement and prompts.

With each retelling of the incident, the child will be prompted for greater detail such as what they were feeling or thinking at various times, as this heightens the child's engagement with their memories. Always make sure that the child says what they were feeling and thinking at important points throughout the story. They may offer feelings and omit what they were thinking, so prompt for this information. When these thoughts and feelings are identified, they need to be added to the book as extra text or additions made to pictures.

Process issues

- The therapist will need to be attuned to the child's emotional response to various parts of the story, so that they can determine which aspects are more distressing than others. These can be focused on in later repetitions of the incident once the fear response has begun to habituate.
- The therapist will use their clinical judgment and intermittent administration of the SUDS scale to determine the child's level of arousal during the exposure process. If children report feeling little distress, greater engagement with the imagined scenario will be required. This can be achieved by asking for more detail about the child's thoughts and feelings during the incident. If the child reports feeling very distressed, the therapist should offer verbal support to the child, i.e. "you're doing really well, I know this is difficult", "you are safe here", and adjust the level of exposure accordingly. *Note:* Take a SUDS recording immediately pre and post the exposure activity also. This can be used as evidence for the child that the exposure is working.
- The child should be reassured and encouraged throughout the exposure exercise, and praised upon completing it.

Exposure occurs later on in the 7-week programme so that children have already learned some skills at emotion regulation (calm breathing and muscle relaxation) should they become extremely distressed during the process, with the fear not apparently habituating. It is essential however for the child to be engaged with their memory of the incident and to be in a state of arousal for the exposure to be effective.

End the session with grounding: The therapist and child should practise the relaxation skills after the exposure component of each session (see Week 3 notes), to ensure the child is not distressed upon leaving the room. During the relaxation exercise it would be useful to reassure the child that they are safe. Affirm the child for doing so well during the exposure in today's session, then proceed to talk about their homework for the coming week (and anything else that helps them to relax again).

Activity for home

GIVE CHILD HANDOUT **Child Session Summary.**

A small reward for starting the exposure and doing well.

To sit down with the parent who is also attending the programme, and tell them what they did in the session today, using the outline handout as a guide.

To keep practising relaxation and challenging stinking thinking.

Week 4
Small Group Session—More on Stinking Thinking 1

More on Stinking Thinking

The goal of the structured component of these small group sessions is to practise identifying stinking thinking, initially using scenarios so that the children can learn in the abstract (non-threatening) before applying the principles to themselves (in Week 6). Themes of inflated perceptions of control and responsibility will be the focus. Children will then be taught how to challenge stinking thinking, before exploring and challenging their own stinking thinking (in Week 6).

Stinking thinking scenarios

To reinforce the children's understanding of stinking thinking and how it relates to feelings, the small group session this week and the next two weeks will cover four scenarios where the children are asked to brainstorm, e.g. –What might this person's thoughts be”, and –How might this person feel if they were thinking that?” The scenarios will cover past, present and future oriented scenarios, so that the child can see that stinking thinking can occur with respect to future events and things that happened in the past. Write children's responses on the whiteboard. Also inquire about how the protagonist might behave in each situation, to make the connection between thoughts, feelings & behaviours. Be careful not to confuse children with the CBT model however, by delivering too much information for them to process. The link to behaviours might best be made through the activity rather than by presenting it explicitly (in a didactic manner).

Children may find it difficult to differentiate between thoughts and feelings, and this will become apparent when they are brainstorming what the protagonist might be thinking in each scenario. If this happens, make it clear to the children that thoughts and feelings are related but different. And prompt for thoughts rather than feelings; e.g., –Yes she might be feeling sad, but why would she feel that way, what is she thinking about what happened...”. Offer the answer if children are unable to make the connection, and practise with another example.

Scenario 1 (general)

A girl called Sally is new to her school, she has been there about a month, and she has made some new friends. One day she sees one of her new friends in the playground and starts to walk over to talk to her. The other girl started walking in the opposite direction, and when Sally yelled out to the girl, she didn't turn around or reply.

Questions:

- What might Sally be feeling? What do you think Sally is thinking to feel this way? What might she do in this situation (to feel better)?
- What are some other examples of what Sally might be thinking?

Determine as a group which examples are stinking thinking and which are OK thoughts.

Why is stinking thinking bad for us?

Draw the children's attention to the fact that in the previous activity, even though the situation was the same, we could come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it. Our thinking only becomes stinking if the thoughts make us feel bad and aren't necessarily true. Stinking thinking makes

us feel bad, and that is why we say it stinks—the thoughts make the child feel bad, when there might be another more helpful way of looking at the situation.

Week 5 Individual Session 4

Exposure with Challenging

The goal of today's session is to continue with the graded imaginal exposure, and to incorporate appropriate challenging of any 'stinking thinking' (distorted thoughts and/or beliefs maintaining the fear). The child should be given the opportunity to practise challenging their own thoughts with the assistance of the therapist.

Outline

- ◆ Weekly SUDS rating
- ◆ Weekly review of progress re: problematic behaviour
- ◆ Review of last week's session & home activity (practise SIT & reward for starting exposure)
- ◆ Graded imaginal exposure (40 mins)—child continues to tell their story, in increasing detail
- ◆ Identification of 'stinking thinking', with appropriate challenging
- ◆ Relaxation
- ◆ Activity for home

Materials

- ◆ Weekly SUDS scale
- ◆ Bear cards (as therapeutic tool)
- ◆ Exposure work from last week
- ◆ Drawing paper and a range of textas/pencils/crayons
- ◆ Some toys/puppets
- ◆ Handout: Child Session Summary

Therapist Guidelines

Weekly SUDS rating

“If I asked you to think about _____ (fighting between parents, a specific incident—whatever the child reports being most fearful of) right now, to imagine you are there and it is happening, how scared do you feel on a scale of 0-10 (where 0 = not scared at all, and 10 = the most scared you have ever been).”

Exposure

Continue with the exposure activity (the child re-tells their story with increasing detail) as outlined in Week 4. Interweave challenging questions into their story by stopping them at various points in the story to ask what they are thinking, and challenging the truth, validity, or likelihood of the thought (if 'stinking thinking'). The eventual goal with the challenging is to help the child acquire more adaptive and rational beliefs and perceptions of their experience (e.g., “it's not my fault”). Remember that the therapist's role is not to guarantee that the child will never experience or be exposed to the feared stimuli again, but to facilitate their development of more rational beliefs regarding these feared stimuli, and to equip them with some skills that can help them cope better with such experiences.

Identification of ‘stinking thinking’ and challenging

By this stage the child will have identified their thoughts at various stages during their story, and the therapist will have a clear idea about any cognitive distortions held by the child, in preparation for this session. The therapist should pay special attention to beliefs around themes of personal responsibility and control for the trauma. As the child acts out using dolls, draws or reads through their story (or in the case of young children, the therapist reads the narrative with the child as the child looks through the book and imagines the event), the story will describe the child’s thoughts at various times during the incident. Where there are identified distortions, ask the child—“Is this ‘stinking thinking’ or good thinking?”. Together with the child, examine the ‘stinking thinking’ by asking rational questions which draw out the ‘stinking thinking’ to its logical and usually unrealistic conclusion (i.e., socratic questioning). Some children will have a better grasp of how to challenge their thinking than others. Some children might have already challenged the ‘stinking thinking’ they held when the trauma happened, and in this instance have them work through with you how they challenged their thoughts. It is important to assist the child to see the errors in their thinking, rather than to simply tell them that they are wrong and that they should think something else.

In challenging the child’s thoughts, be careful not to disengage them from the exposure. Keep the challenging brief where possible, and get straight back into the exposure activity.

The therapist and child should practise the relaxation skills after the exposure component of each session (see Week 3), to ensure the child is not distressed upon leaving the room. During the relaxation exercise it would be useful to reassure the child that they are safe. Remember to use the SUDS liberally as appropriate to monitor the child’s distress throughout the session and especially before they leave.

Activity for home

GIVE CHILD HANDOUT **Child Session Summary.**

To sit down with the parent who is also attending the programme, and tell them what they did in the session today, using the outline handout as a guide.

To keep practising relaxation and challenging stinking thinking.

Week 5
Small Group Session—More on ‘Stinking Thinking’ 2

‘Stinking thinking’ scenarios

To reinforce the children’s understanding of ‘stinking thinking’ and how it relates to feelings, the small group session this week will present two more scenarios where the children are asked to brainstorm, e.g. –What might this person’s thoughts be’, and –How might this person feel if they were thinking that?’ Write children’s responses on the whiteboard. Also inquire about how the protagonist might behave in each situation, to make the connection between thoughts, feelings & behaviours. Remember not to confuse children with the CBT model by delivering too much information for them to process. The link to behaviours might best be made through the activity rather than by presenting it explicitly (in a didactic manner).

Children may find it difficult to differentiate between thoughts and feelings, and this will become apparent when they are brainstorming what the protagonist might be thinking in each scenario. If this happens, make it clear to the children that thoughts and feelings are related but different. And prompt for thoughts rather than feelings; e.g., –Yes she might be feeling sad, but why would she feel that way, what is she thinking about what happened...’. Offer the answer if children are unable to make the connection, and practise with another example.

Scenario 2 (general)

Tom has just found out that he has failed a maths test at school. He usually does OK in tests, but maths is the subject he finds hardest.

Questions:

- What might Tom be feeling? What do you think Tom is thinking to feel this way? What might he do in this situation (to feel better)?
- What are some other examples of how Tom might be thinking?

Determine as a group which examples are ‘stinking thinking’ and which are OK thoughts.

Scenario 3 (specific)

Judy and her sister are very close, and care a lot about each other. Judy usually looks after her sister when she needs help, or when their parents aren’t nearby. She likes to take care of her sister. Judy has just found out that her younger sister is unwell, and needs to go to hospital. Judy feels guilty.

Questions:

- ◆ We know what Judy is feeling in this situation; she is feeling guilty about her sister going into hospital. What do you think Judy is thinking to feel this way? What might she do in this situation?
- ◆ What are some other examples of how Judy could think about this situation?

Determine as a group which examples are ‘stinking thinking’ and which are OK thoughts.

Why is stinking thinking bad for us?

Draw the children's attention to the fact that in the previous activity, even though the situation was the same, we could come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it. Our thinking only becomes stinking if the thoughts make us feel bad and aren't necessarily true. 'Stinking thinking' makes us feel bad, and that is why we say it stinks—the thoughts make the child feel bad, when there might be another more helpful way of looking at the situation.

Ask the children to identify an example of 'stinking thinking' in themselves between now and next week (mum &/or dad to assist) to discuss in the next session, during which time the child will be encouraged to think of another possible (positive) thought for the situation.

Week 6

Individual Session 5

Exposure With Challenging, and Future Planning

In this session you will continue with the exposure component of the treatment programme, with appropriate challenging of ‘stinking thinking’. The child will also be encouraged to think of future situations relating to their parents which they feel worried/anxious about. Together with the therapist, the child will use what they have learned during preceding sessions to devise a plan to deal with those situations.

Outline

- ◆ Weekly SUDS rating
- ◆ Weekly review of progress re: problematic behaviour
- ◆ Review of last week’s session & home activity – practise SIT, challenging stinking thinking, and (for the small group session) think of one example of their own stinking thinking
- ◆ Exposure – child continues to tell their story, with increasing detail
- ◆ More on ‘stinking thinking’, with appropriate challenging
- ◆ Planning for future stressful situations
- ◆ Relaxation
- ◆ Activity for home

Materials

- ◆ SUDS scale
- ◆ Bear Cards (as therapeutic tool)
- ◆ Exposure work from previous weeks
- ◆ Drawing paper and a range of textas/pencils/crayons
- ◆ Some toys/puppets
- ◆ Handout: Child Session Summary

Therapist Guidelines

Weekly SUDS rating

–If I asked you to think about _____ (fighting between parents, a specific incident—whatever the child reports being most fearful of) right now, to imagine you are there and it is happening, how scared do you feel on a scale of 0-10 (where 0 = not scared at all, and 10 = the most scared you have ever been).”

Exposure

Continue with the exposure activity (the child re-tells their story with increasing detail) as outlined in Week 4. If the child’s symptoms do not appear to be improving, have them tell their story in the present tense, rather than using past tense.

The therapist and child should practise the relaxation skills after the exposure component of each session (see Week 3), to ensure the child is not distressed upon leaving the room. During the relaxation exercise it would be useful to reassure the child that they are safe.

Identification of ‘stinking thinking’ and challenging

Continue with challenging cognitive distortions, as outlined in Week 5.

Planning for future stressful situations

Ask the child to think forward to an event in the future that they feel worried about. Discuss with the child what they fear will happen. Explore with them what they might do in the situation, using the skills learned in previous weeks. Develop a clear plan as to what the child could do. It is likely that the feared situation is one where both parents will meet and be in conflict, and this is likely to be at handover. Encourage the child to use the skills they have been taught, to relax, avoid stinking thinking (“it is not my responsibility to prevent this”), and also to behave assertively. Assertive behaviour in this situation could include removing themselves from the scene and waiting in the car or in the house, possibly distracting themselves by reading a book or some other activity. Brainstorm options with the child and come up with a plan.

Activity for home

GIVE CHILD HANDOUT **Child Session Summary.**

To sit down with the parent who is also attending the programme, and tell them what they did in the session today, using the outline handout as a guide.

To keep practising relaxation and challenging stinking thinking.

To use this plan for the ‘future stressful situation’ and feedback how it went.

Week 6

Small Group Session—More on ‘Stinking Thinking’ 3

‘Stinking thinking’ scenarios

This is the last time the children will be meeting in their small groups. To reinforce the children’s understanding of ‘stinking thinking’ and how it relates to feelings, the small group session this week will present one last scenario requiring the children to brainstorm, e.g. –“What might this person’s thoughts be”, and –“How might this person feel if they were thinking that?” Write children’s responses on the whiteboard. Also inquire about how the protagonist might behave in each situation, to make the connection between thoughts, feelings & behaviours. Remember not to confuse children with the CBT model by delivering too much information for them to process. The link to behaviours might best be made through the activity rather than by presenting it explicitly (in a didactic manner).

Children may find it difficult to differentiate between thoughts and feelings, and this will become apparent when they are brainstorming what the protagonist might be thinking in each scenario. If this happens, make it clear to the children that thoughts and feelings are related but different. And prompt for thoughts rather than feelings; e.g., –“Yes she might be feeling sad, but why would she feel that way, what is she thinking about what happened...”. Offer the answer if children are unable to make the connection, and practise with another example.

Scenario 4 (specific)

It is Harry’s birthday on the weekend coming up and he is having two of his best friends over to play. One of these friends is Harry’s neighbour; the other friend is a boy from school. These two boys don’t know each other very well, but they always fight when they play together. Harry is starting to feel worried and is laying awake at night thinking of ways that he can make his friends get along.

Questions:

- We know what Harry is feeling in this situation, he is feeling worried about his friends fighting. We also know what he is going to do in this situation, he is spending his time worrying and thinking about what he can do to make them get along. What do you think Tom is thinking to feel this way? (*that it is his responsibility that his friends get along*).
- What are some other examples of how Tom could think about this situation?

Determine as a group which examples are ‘stinking thinking’ and which are OK thoughts.

Why is stinking thinking bad for us?

Draw the children’s attention to the fact that in the previous activity, even though the situation was the same, we could come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it. Our thinking only becomes stinking if the thoughts make us feel bad and aren’t necessarily true. ‘Stinking thinking’ makes us feel bad, and that is why we say it stinks—the thoughts make the child feel bad, when there might be another more helpful way of looking at the situation.

Do I have stinking thinking‘?

Ask the children if they can think of any times that they may have had stinking thinking‘ in relation to their parents‘ fighting/separation. When? What did they think? How did they feel? What did they do? *The therapist should also have some idea of this from earlier assessments and individual sessions.*

GIVE WEEK 6 CHILD HANDOUT/WORKSHEET, –Challenging Stinking Thinking”.

Help children to come up with their own example, because these will be used in the next activity on challenging. Ask children to write down these examples in the worksheet provided.

Group leaders might need to begin this activity by providing some examples of their own. Focus this discussion on those cognitive distortions believed to be most distressing to these children—distortions around control and responsibility. If others come up that have relevance to maintaining the child’s fear around their parents‘ conflict, also focus on those.

Challenging stinking thinking‘

So what can we do about stinking thinking‘?

Using the scenarios already described, and the ideas put forward by the group as to what the person might be thinking and thus feeling, identify those thoughts that are examples of stinking thinking‘. –See however, that we were able to come up with some examples that did not make the person feel bad.”

–When we see stinking thinking‘ we can ask ourselves questions like:

- ◆ Is there another way to look at this situation?
- ◆ Is that thought accurate?
- ◆ Is that thought helpful?
- ◆ *(For older children) What would I say to my best friend if they were in this situation?”*

Using the examples of stinking thinking‘ offered by the children, work around the group and challenge each person’s negative thinking, by answering the above questions, and any others that are appropriate to the example. Using alternative ways of thinking about their situation, work through the scenario to determine how they might feel and act using the alternative positive‘ thinking offered. Ask children to write down their answers in the worksheet provided.

—When you feel yourself getting upset in a situation, stop and ask yourself these questions, because there might be a better, more realistic and more helpful ways of thinking about the situation. Changing the way we think doesn’t happen overnight, it takes effort to stop yourself when you notice yourself feeling upset, and question your stinking thinking‘ like we just did together. You can try doing this for all sorts of situations when you notice yourself getting upset.”

Farewell to the group

Since this is the last time the group will be meeting together, end the session by thanking the children for participating in the group and encourage/allow them to bid farewell to one another before they leave.

Week 7

Combined Parent & Child Session 2

Moving On

The goal of this session is for the parent and child to share what they have learned over the duration of the programme, and to talk about any changes they have noticed in themselves or their family (notably, the problematic behaviour identified in week 1, the child's sense of wellbeing, their adjustment more broadly, the parent/child relationship). It will give them a chance to consolidate what they have learned, and think about how they can use the skills and knowledge to plan for future stressful situations. It also allows them to feedback their experience of the programme, and formally end the therapeutic contact.

Outline

Parent & Child

- ◆ Weekly SUDS scale
- ◆ Weekly review of progress re: problematic behaviour (“How far have I come?”)
- ◆ Review of home activity
- ◆ Parent & child share what they have learnt, what has changed and how?
- ◆ What did you like and dislike?
- ◆ What was useful and what was not?
- ◆ Brief review of the child's programme – feelings, relaxation, ‘stinking thinking’, challenging ‘stinking thinking’, confronting fears (exposure work)
- ◆ Brief review of the parent's programme – the impact of parental conflict on children, how you can support your child, how to reduce the conflict, skills in positive parenting.
- ◆ Planning for future stressful situations, what each party can do.

Materials

- ◆ SUDS scale
- ◆ Butcher paper and thick textas
- ◆ Drawing paper and a range of textas/pencils/crayons
- ◆ 2 handouts: Parent and Child Session Summary

Therapist Guidelines

In the final review of weekly SUDS and the review of the earlier identified problematic behaviours, compare current ratings to those made in the first sessions, to demonstrate the improvement that has been achieved. Congratulate this.

Have the parent and child feedback how they feel things have changed since beginning the programme—probe around behaviours, emotional wellbeing, general coping, adjustment in other areas of life, relationships etc. This should take the form of a discussion. Feedback where appropriate how you see that things have changed for the parent and child.

Provide both the parent and the child with the opportunity to feedback what they felt was useful and not so useful. What aspects of the programme did they enjoy and what aspects did they not enjoy?

Summarise the key concepts and skills within the child and parent programmes

Use your knowledge of the programme to do this, invite input from the child or parent.

The child's programme included - feelings, relaxation, 'stinking thinking', challenging 'stinking thinking', and confronting fears (exposure work).

The parent's programme included – the impact of parental conflict on children, how you can support your child, how to reduce the conflict, skills in positive parenting. These need to be worded in a way that is appropriate for the child to hear.

Planning for future stressful situations

Following on from this activity last week with the child, discuss what each party can do in the feared situations they each raise. Reinforce the skills they have learned.

GIVE PARENT AND CHILD HANDOUTS **Parent and Child Session Summary.**

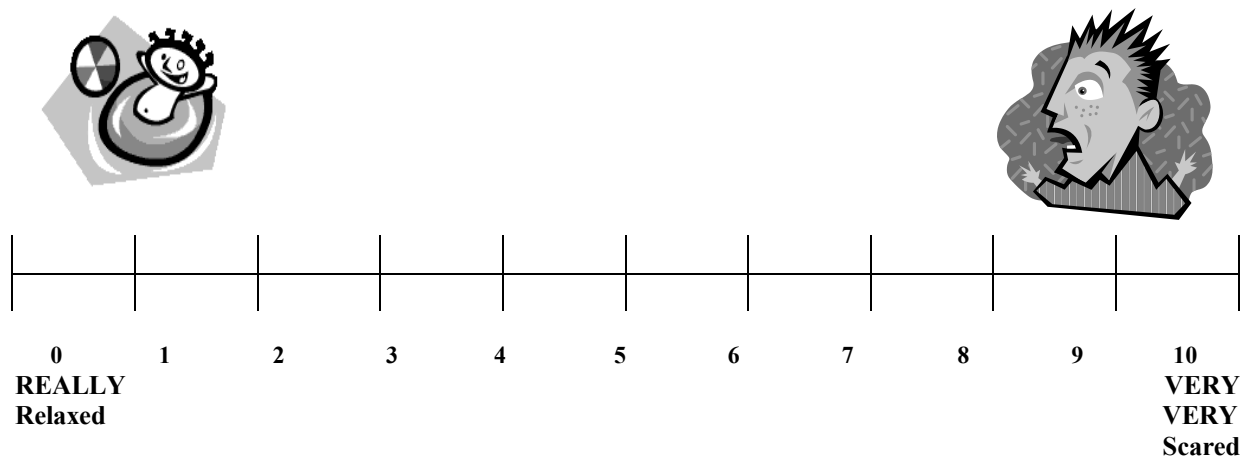
Saying goodbyes

Finish the programme on a positive note. Thank the family for being involved, and feedback the advances you believe they have made. Make a time for follow-up assessment.

Appendix 1

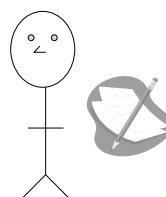
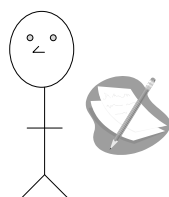
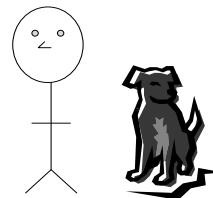
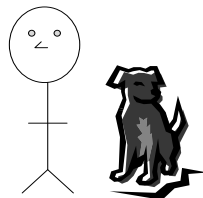
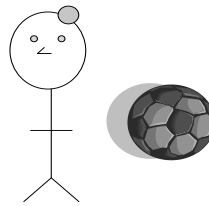
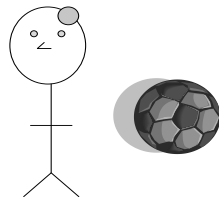
SUDS Scale (sample)

The SUDS scale



Appendix 2

Thoughts & Feelings Scenarios (Sample)



Appendix 3

Week 2 Individual Session 1: Stinking Thinking

In the week ahead, each time a thought makes you feel bad or sad, write it down or draw a picture of what happened and what you were thinking next to the day/date it occurred. Bring this worksheet with you to the next session.

Day/Date	Stinking thinking 1	Stinking thinking 2	Stinking thinking 3
Day 1:			
Day 2:			
Day 3:			
Day 4:			
Day 5:			
Day 6:			
Day 7:			

Appendix 4

Warm Up Games or Icebreakers

Goal – To help decrease anxiety about being part of the group, facilitate group members getting to know each other better, and to promote group processes.

M&M's

Pass around the circle a small bowl of M&M's, and say to the children –“You can take up to 5 M&M's if you like, take no more than 5 so that there are enough for everybody, but don't eat them just yet”. One of the leaders should go first, and take around 3-4 M&M's and hold them in their hands. Once everybody has taken some M&M's, ask the children to count how many M&M's they have taken. Then tell them that in the next exercise each person will tell the group some things about themselves that the group doesn't know. If they have 2 M&M's they will have to TELL the group 2 things, if they took 8 M&M's they will have to tell the group 8 things. One of the leaders will start by saying, –“I have 4 M&M's, so I will tell the group 4 things about myself that you won't know. I have a dog at home called _____. My favourite food is _____. I like to _____ on the weekend. My favourite time of the year is _____ because _____.” Move around the circle.

Toilet Tissue Pass

Pass around a roll of toilet tissue and ask everyone to take as much as they'll need. After the roll has been shared with everyone, ask everyone to introduce self and say a positive thing about themselves for each sheet of tissue they have. They could tell about their family. This could also be used to list the different jobs/roles they have in the family or list the positive things about their family members.

Allow Me to Introduce to You...

Ask your group members to pair up with someone they have just met, or someone that they do not know well. Have pairs position themselves around the room, so they can talk together comfortably. Each person is to find out a little about the other person, so they can introduce them to the rest of the group. Suggested topics of conversation could include: name, home town, year in school, hobbies, sports, favourite subjects, favourite animals, and the like. After giving each partner 3 to 4 minutes to talk, bring the group back together, and have them sit in a circle. In turn, each person stands and introduces their partner to the group.

Sentence Completion

Using sentence completions allows each person to share something about themselves. Make this fun and on the light side, not too serious. These can be put on a handout or on a wall poster.

Examples:

- ◆ The comic character I would like to be like is.
- ◆ My favourite game is.
- ◆ My favourite movie is.
- ◆ What makes me laugh is.

Hackey Sack

Work around the circle and get each group member to say their name. We are going to throw this hackey sack to each other, but before you throw it you will need to say the name of the person you are throwing it to. If you have forgotten the other person's name, you might need to ask them their name first. Have a group leader start the exercise by saying the name of the other leader as they throw them the hackey sack (check that the children understand how the exercise works). Then the receiver says the name of one of the children and throws them the hackey sack. After a few rounds, when the children are comfortable with the exercise, speed it up, and change the rules so that you can't catch the hackey sack but you can't let it touch the ground.

Appendix 5

SIT cards (Sample)

Calm Breathing

To use when I am scared or worried

- *Hand on your tummy (watch it move)*
- *One breath from deep down*
- *Breathe out very slowly*
- *Say 'calm'*

Tense & Relax

- *Sit quietly*
- *Squash the grapes - push down with your legs, feet and toes*
- *Relax*
- *Reach for the ball in the tree - reach up as far as you can with your arms and hands*
- *Relax*
- *Get the beetle off your face - scrunch up your face*
- *Relax*

Appendix 6

Session Outlines

Week 1

Today in my session |....

- Met _____
 - Talked about confidentiality – that things I say are private, unless my therapist thinks I might be in danger, then she/he will tell mum or dad.
 - Talked about what we will do over the next few weeks
 - Talk about feelings
 - Talk about thoughts and how they can sometimes make us feel bad
 - Meet some other kids who have parents who fight
 - Learn some things I can do when I feel rotten
 - Talk about the fighting between my mum & dad
 - My homework today is: To reward myself for coming in to my first session by
-

Week 2

Today in my session |....

- Got to know _____ a bit better

- Talked about feelings:
 - like worry and anger
 - what they feel like in my body
 - when I might feel that way

- Talked about 'stinking thinking'
 - it is thoughts that make me feel bad
 - and they are usually not even true

- My homework today is:
 - To sit down with mum/dad and tell them what I learned today, using this sheet

 - To keep a look out for my own 'stinking thinking', writing them in the worksheet (I'll need to bring this worksheet to next week's session when we will talk more about these examples of 'stinking thinking').

Week 3

Today in my session with all the other kids we....

- o Talked more about feelings
 - like the way I feel when I think about mum and dad fighting
 - and what I do to make myself feel better

 - o Learned some ways to help myself feel better (they gave us small cards to help us remember how to do these)
 - CALM BREATHING
(For when I am scared and my heart is racing)
 - ◆ Take a slow, deep breath from down in my tummy
 - ◆ Feel my lungs get bigger
 - ◆ Breathe out really slowly and quietly say 'calm'
 - ◆ Do this 10 times or more until I feel calmer

 - TIGHTEN AND RELAX
(For when my muscles are tight and sore)
 - ◆ Squash grapes into the ground, then relax
 - ◆ Reach up for the ball in the tree, then relax
 - ◆ Squeeze the juice from oranges in my hands, relax
 - ◆ Get the beetle off my face, no hands, then relax

 - o My homework today is:
 - To sit down with mum/dad and tell them what I learned today, using this sheet
 - To practise the 'calm breathing' and 'tighten and relax' each day at home, using my card. I will do this
-

Week 4

Today in my session alone with the therapist]...

- Talked about the memories of mum & dad fighting that scare me the most, and started my own book about it
- I talked about what happened over and over again, and told the therapist how I was feeling at different times.
- This is called 'exposure' and although it is hard work, it will help me to stop feeling so scared about what happened.
- My homework today is:
 - To sit down with mum/dad and tell them what I learned today, using this sheet
 - This week I get a small treat for starting the exposure and doing well
 - To keep practising the 'calm breathing' and 'tighten and relax' each day at home, using my card.

Today in my session with the other kids we...

- Were given an example about Sally at the new school, and we had to say if there was any 'stinking thinking' happening, and then to give some other 'good thoughts' to replace the stinking ones.
- Saw that even though the situation is the same, we can come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it.

Week 5

Today in my session alone with the therapist I...

- Did some more exposure – I talked more about the memories of mum & dad fighting that scare me the most, and told the therapist how I was feeling at different times.
- I kept adding to my book about what happened.
- This time I also had to think about where the ‘stinking thinking’ was in my story, and the therapist helped me to ask the questions:
 - Is there another way I can look at this situation? (Yes)
 - Is that stinking thought really the truth? (hardly ever)
 - Does that stinking thought help me? (no!!!)
- I came up with some good thoughts to replace the stinking ones.
- My homework today is:
 - To sit down with mum/dad and tell them what I learned today, using this sheet
 - To notice when I have ‘stinking thinking’, ask myself the questions, and come up with a better thought. Think of one example to bring to next week’s group session
 - To keep practising the ‘calm breathing’ and ‘tighten and relax’ each day at home, using my card.

Today in my session with the other kids we...

- Were given 2 examples (about Tom failing his Maths test, and about Judy and her sister) and we had to say if there was any ‘stinking thinking’ happening, and then to give some other ‘good thoughts’ to replace the stinking ones.
- Saw that even though the situation is the same, we can come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it.

Week 6

Today in my session |...

- Did some more exposure – I talked more about the memories of mum & dad fighting that scare me the most, and told the therapist how I was feeling at different times. (Have you noticed that you are starting to feel better about the scary memories?)
- I also practised using some good thoughts to replace the stinking ones in my story.
- I worked out a plan of what I can do in future situations that I am worried about (like when mum & dad meet up next). I plan to use all the things I have learned in the sessions so far:
 - like calm breathing
 - replacing my ‘stinking thinking’ with helpful thoughts
 - and to go and sit in the car or in the house if fighting starts, because it is not my responsibility and I’d rather feel good
- My homework today is:
 - To sit down with mum/dad and tell them what I learned today, using this sheet
 - To practice using my plan if I get the chance
 - To notice when I have ‘stinking thinking’, ask myself the questions, and come up with a better thought
 - To keep practising the ‘calm breathing’ and ‘tighten and relax’ each day at home, using my card.

Today in my session with the other kids we...

- Were given an example about Harry’s birthday and his two best friends, and we had to say if there was any ‘stinking thinking’ happening, and then to give some other ‘good thoughts’ to replace the stinking ones.

- Thought about my own 'stinking thinking'
 - like some kids with parents who fight blame themselves
 - and some kids think it is their job to make their parents stop fighting

- Talked about how to stop the 'stinking thinking' by asking ourselves when we feel bad about something:
 - Is there another way I can look at this situation? (Yes)
 - Is that stinking thought really the truth? (hardly ever)
 - Does that stinking thought help me? (no!!!)

- Talked about our own 'stinking thinking' and thought of other ways to look at the situation that are more true, and helpful, and don't make me feel bad.

- Said goodbye to one another because this is the last time we are meeting as a group.

Week 7

Today in my session |...

- Came in with my mum/dad
- Talked about how things have changed at home
- Talked about how things have changed for me
- We told the therapist what we liked and didn't like so much about the programme.
- We talked about the things that we have learned.
- We planned for stressful situations in the future, and talked about what I can do, and what my mum/dad can do.
- We said good bye to the therapist and the programme.
- My homework from now on is:
 - To practise using my plan, and to make other plans for other stressful times
 - To notice when I have 'stinking thinking', ask myself the questions, and come up with a better thought
 - To keep practising the 'calm breathing' and 'tighten and relax' each day at home, using my card.

Appendix 7
Trauma and Sleep—Optional Resource

Purpose Of Sleep

- Restorative: Mental _____
 Muscular _____

- Information Processing: _____

- Hibernation: Protective: _____
 Unprotective: _____

Disturbance of Sleep

- Trouble going to sleep
- Intermittent sleep during the night (keep waking up)
- Nightmares
- Wake early
- Wake late
- _____

Healthy Routine

- Finish work 2 hours before bed
 - –Wind down” e.g. music, read, relaxation, etc
 - No stimulants e.g. _____
 - Instead Use: _____
 - Wait until next wave of sleepiness:
 - Keep pen & paper near bed:
 - If not asleep within 20 minutes get up:
 - If awake and can’t sleep: -Get up
 -Do non-stimulating activity
 -Wait until next wave of sleep to return
 - Arise each morning at a set time even if still tired: e.g.
 - Get out into daylight as soon as possible: where?
- No ‘cat-naps’ during day!

References

Calm Breathing and Progressive muscle relaxation for children adapted from:
Trauma-Focused Cognitive Behavior Therapy—modules on breathing and relaxation techniques

<http://tfcbt.musc.edu/modules/breathing/technique/scripts.php?step=2>

<http://tfcbt.musc.edu/modules/relaxation/technique/scripts.php>

Appendix B: Child Anger Management Module.

Swinburne University of Technology
Brain Sciences Institute.

SEPARATED FAMILIES PROGRAM.

MODULE

Treating Anger Problems in Children Exposed to Conflictual Parental Separation.

Resource for child therapist.

**Fallon Cook
Grant J. Devilly
Susie Sweeper**

AIMS.

The aims of this module are to help the children to:

- Identify how anger *looks* in both themselves and others
- Recognise their own physiological sensations and cognitive *feelings* of anger
- Learn skills and strategies to reduce immediate anger
- Learn to challenge thoughts surrounding anger- incorporating stinking thinking

PROCEDURE.

The material will be covered in small groups on a weekly basis for three consecutive weeks in one hour sessions. Homework and module content will also be briefly discussed during the child's individual therapy sessions.

First session:
For incorporation into week four of therapy program.

Anger identification and expression.

The aim of this session is for the children to:

- Understand what anger looks like in both themselves and others
- Be able to identify how they feel emotionally and physically when they start to feel angry- so that they can identify the signs that they are getting angry,

Ask the children what an angry person looks like.

How can we tell if someone feels angry?

What does your face look like in the mirror if you feel angry?

Get the kids to pull their most angry face in the mirror and then get them to describe it. How does it feel to pull this face? Does anger make us feel good or bad inside?

How does your body feel when you start getting angry? Get the kids suggestions and make a list of things on the white board. Include the following:

- Shaking
- Tight muscles
- Sweating
- Heart beating fast
- Breathing fast
- Nausea

Do we think clearly and sensibly when we are angry? Explain to kids that when we are angry we often have inaccurate or faulty thoughts- stinking thinking.

Give examples-

-She **hates** me”

-He will **never** listen to me”

-**Nobody** likes me”

These thoughts are almost always wrong and they just make us feel even worse.

HOMEWORK.

During the next week the kids will fill out 2 examples on the following sheet when they feel angry about something- they will bring it along to next week’s session.

My Angry Feelings.

Date	What was I angry about?	Did I have:		Did I feel good or bad inside?	Did I have stinking thinking?
		Shaking?	<input type="checkbox"/>		
		Tight muscles?	<input type="checkbox"/>		
		Sweating?	<input type="checkbox"/>		
		Fast Heart Beat?	<input type="checkbox"/>		
		Fast breathing?	<input type="checkbox"/>		
		Sick tummy?	<input type="checkbox"/>		

Date	What was I angry about?	Did I have:		Did I feel good or bad inside?	Did I have stinking thinking?
		Shaking?	<input type="checkbox"/>		
		Tight muscles?	<input type="checkbox"/>		
		Sweating?	<input type="checkbox"/>		
		Fast Heart Beat?	<input type="checkbox"/>		
		Fast breathing?	<input type="checkbox"/>		
		Sick tummy?	<input type="checkbox"/>		

Second session.

Reducing immediate anger

The aim of this session is for the children to:

- Learn to implement strategies to reduce anger such as calm breathing, SIT training and distancing themselves from the situation.
- Discuss how to challenge the “stinking thinking” surrounding their anger.

Explain to the children that once we are already angry, it can be very hard to stop being angry- it is much better if we learn how to stop ourselves from getting angry in the first place.

Review last weeks suggestions of how we can identify when we are starting to get angry- When we have those feelings we MUST do something to stop our anger and make ourselves feel calm and happy again.

Review calm breathing, get the kids to demonstrate.

Review tense and relax- roll into a ball and tighten all your muscles, count to three and then relax. Repeat several times- (this is more appropriate than the full relaxation scripts given previously which are better for anxiety).

When possible it is a good idea to get away from whomever or whatever is making you angry. What can you do to distract yourself from whatever is making you angry? Make a list on the board and include the following:

- Read a book
- Play with toys
- Play a video game
- Go into another room or the backyard.

When we get angry we usually have some stinking thinking or other inaccurate thoughts. Ask the kids how they went with last week’s homework- do they have some examples of stinking thinking from when they were last feeling angry?

Did the stinking thinking make them feel good or bad? Was the stinking thinking accurate? Was it helpful?

What might be a better way of thinking about the situation? Challenge the stinking thinking examples.

HOMEWORK:

To practice the relaxation skills when they feel angry, and to remove themselves from a situation if it is making them angry (when possible).

Third Session.

Challenging thoughts and implementing more effective behaviours.

The aim of this session is for the children to:

- Discuss any angry episodes they have had in the past week and discuss whether the strategies helped.
- Discuss examples of stinking thinking and better ways to think.
- Understand why getting angry never helps improve the situation.

Ask the children if they have been angry in the past week.

Did they try the calm breathing?

Did it make them feel better?

Did they try removing themselves from the situation? Did they have any stinking thinking during the angry episode? If so, what is a better way they could think about the situation?

Read out the following scenario:

–Sarah is waiting in line at the canteen to buy her lunch. Katie pushes in line ahead of Sarah. Sarah starts to feel really mad because she is hungry and wants to eat her lunch straight away, so she starts to yell at Katie and tells her to go to the back of the line. Katie then starts to yell back at Sarah, and a fight starts. Katie and Sarah are both really mad and neither one of them is really listening to the other one. A teacher comes along to stop their arguing and both girls get sent to the quiet chair for some time out and have to wait an extra 5 minutes to get their lunches. Both are very unhappy and still feel quite mad at each other.”

–If Sarah had taken a deep breath and then spoken in a calm voice to Katie, what might have been different in this scenario?” (Katie might not have yelled back, teacher might not have punished them, they would have gotten their lunch sooner etc)

Did getting angry help Sarah? Did getting angry make the situation better or worse?

Explain to the kids that when you yell at someone, people don't really listen to what you are saying anymore.

It is better to keep a calm voice and avoid shouting. Stay calm and if the other person is angry or just isn't listening to you then it is best to walk away and do something else. It is better to wait and discuss the problem when everyone has calmed down a bit.

Appendix C: Parent Group Manual.

Note: The numbered Appendices referred to in this manual refer not to the Appendices within this thesis, but to the Appendices that occur at the end of the manual.

**Parent Group – Session 1
Week 2 of program**

Introductions and Impact of Conflict on my Child

Therapist Guidelines

As participants come into the room or as they are greeted at reception give them a name tag.

Starting off the session

□START ON TIME!!!! This is really important for the first session because you don't want the participants to have an expectation from day 1 that it is ok to turn up late and not miss anything.

Aims of this week

1. Set up the group dynamic and inform parents of what will be expected of them in the group including rules
2. Instill in parents an understanding of the significant negative impact of parental conflict on their child
3. Teach parents about 'sinking thinking'

Outline

1. Introduction to the group
 - Expectations of the group and rules
 - Review of homework and progress re: target behaviour
 - Impact of the conflictual parental relationship
 - Summary of what the children are doing this week- introduction to feelings identification/expression & 'sinking thinking.'
 - Homework

Materials

- Name tags
- A whiteboard or butcher paper and markers
- DVD on conflict 'Consider the Children'
- 1 worksheet ('The Impact of the Conflictual Parental Separation') and 4 handouts ('Child Trauma responses', 'Child Reactions to Separation', 'Anxiety and Stress Responses', and Parent Session Summary)

Introduction to the Group

As group leader you will introduce yourself, and summarise for parents your background and experience. This is an important factor in motivating parents to participate fully in the group, and to instill in parents a sense that the group leader possesses expertise in the field.

Introduce the program

Tell parents that their part of the program is to learn new parenting skills- both in terms of how to manage their children and their relationship with their former partner. Most importantly it is about conflict that may have been occurring and how you and your children have been coping with it. The programme is not interested in blaming either parent; our focus is purely on how to support the child who is experiencing difficulty, and to teach parents the skills to do that. You are parents are here to learn how to support your children.

Discuss what will be done tonight.

Family Tree Exercise

Ask them to share their name, names of their children and ages and a brief statement about why they are here and what they want to learn. The facilitator needs to summarise the statements about why the people are here – point out areas of convergence and divergence between participants.

Responses usually include the following:

Learn how to protect the kids from the harm/effects of conflict

How can I support my children

How can I talk to my children

What should I tell my children

How can I talk with my ex

How to parent long distance

How do I deal with my ex when we don't like each other?

Also use this section to normalise how people feel. Say things like –“Yes, lots of parents feel like that”.

In this part of the program reiterate to the participants that the number 1 purpose of the group is to help the kids. Most importantly we want to reduce conflict between former partners which in turn will benefit the children.

As a facilitator make sure to memorise the children's names as well!!!!

Do the family tree exercise. In this exercise draw a tree on a piece of cardboard and for each participant write their name on a branch and their children's names coming off the branch. On the trunk of the tree write 'PSPG' (Post Separation Parents Group) and put the names of the facilitators on the roots of the tree (as adapted by Wolchik).

Give this to the Program Manager to photocopy to give to parents next week.

Expectations of the group and rules

It is important to spend some time setting up group rules so that all members can feel comfortable about discussing personal issues in sessions. Have the member's offer rules that they feel are important, and write them up on a large piece of paper, so that each week you can hang the rules in the room and refer to them at the start of each session to refresh the members' memories. Have a facilitator make a handout of the rules and give to participants.

After inviting the members to offer rules, also make sure that you include:

1) Confidentiality: No discussing of individual cases outside of this room. Highlight the importance of this rule in allowing the members to feel comfortable sharing personal information. By all means members can talk about skills they have learnt, but not personal details of fellow group members.

2) Respect for all members: Everyone here has different experiences and we must all respect those individual differences. Try not to ridicule or criticize other members of the group.

Everybody should get the chance to speak and be listened to respectfully.

3) Punctuality and attendance. All members and the leader must commit to attending all sessions and being on time. If you can't make a session due to illness or something else, you need to call the group leader beforehand.

4) Attempt homework assignments: All members must commit to carrying out the homework- it is through applying the things learned that you will see change.

5) If you have questions please ask them as we go. It is important to ask questions when you are unsure of something.

6) Participate as best you can: This means you do not have to disclose everything. There may be some issues you do not want to discuss in the whole group. Just disclose as much as you feel comfortable. Though I do believe that one of the benefits of having a group like this is that you can learn from one another, the key is to just feel comfortable about what you disclose.

7) Speak one at a time. No interrupting. Listen to other group members.

8) No aggressive behaviour – know what your buttons are and try to self-regulate your emotions – do not be triggered. Respond respectfully when you have a different point of view.

Review of homework and progress re: target behaviour

Work around the circle, and ask each parent how the child's homework went (to get a small treat for attending the first session), any problems, any observed benefits, any questions?

Also ask about the problematic behaviour identified by the parent in the first session—has there been any change in the behaviour, how is the child going with their reward system, and does the parent have any questions or comments? Enquire about how the child is functioning generally, any feedback from teachers or observable differences in behaviour, sociability, emotional wellbeing, symptoms of fear etc.

Also check in regarding the parents' homework (to give themselves a small treat for coming to the first session), how it went, any problems, any observed benefits, any questions or comments?

During this process, reiterate the importance of the homework, and that practicing will produce greater benefits. Use the time to brainstorm solutions with the group to any problems raised by a parent. Use the time to also reiterate why that particular exercise is important, consolidating the knowledge learned in the previous week.

This part of the session can be structured flexibly, depending on how the group works and what they bring to the discussion. There needn't be a specific order to the questions asked.

Impact of the conflictual parental relationship

Children are very sensitive to conflict between their parents, and they can be badly affected by conflict which continues after separation.

Research shows quite clearly that conflict between parents is the most critical factor which affects children's adjustment after separation.

Children who feel that they are 'the meat in the sandwich' are the ones who are the most seriously affected by the conflict. If the conflict between parents continues, children may become distressed every time they go from one parent to the other. They may feel pressure to take sides. They may have ongoing problems at school, and, at worst, their development may be seriously hampered.

Children who witness intense conflict or violence between parents are at risk of developing long-term emotional problems. The effect on children of seeing or hearing a parent being hurt is similar to the child being hurt him/herself.

Common Reactions of children to separation

(Give parent the handout: –The impact of the conflictual parental relationship” but do this activity on the whiteboard, parents can take home the sheet to fill out for their own kids if they want to)

Divide the whiteboard into two sections with a line down the middle. On the first half write –Changes/Losses for the children”. Ask participants what are some of the losses/changes your children have experienced.

Using the second column of the white board ask the participants what they think are common reactions or concerns in children when their parents separate. Where possible ask them to relate it to their own children. Discuss the research around this topic.

Discuss how the two sides are related. Say things like children don’t have as good or well developed coping mechanisms as adults and sometimes that is why they misbehave more.

Ask them if they have noticed any changes in their relationship with their children since separation? Remember to normalise their responses where necessary. Emphasise - But also say that while they maybe normal they still need your parental attendance.

When doing this exercise make sure to include some of the following.

Changes or Losses for Children	Children’s concerns/reactions about separation
Move school	Fears of abandonment
Don’t see dad as often	Feeling sad about less time with parents
Move house	Feels caught in the middle between parents
Lost a sense of security	Become really quiet
Moved away from best friend	Become very naughty
Don’t see mum and dad fighting	Wets the bed
Has a new step-mother	

The purpose of this directed discussion is to orient parents to thinking about the impact of the conflictual parental relationship on the child, to put themselves in the child’s shoes and try to understand the broad impacts on the child’s functioning—emotionally, physically, academically, socially etc. For example, if the child is fearful and worried about what has been happening at home, they might become socially withdrawn, more argumentative with peers, their behaviour might become more challenging (impacting on their relationship with each parent and other siblings), and they might have difficulty concentrating at school. Bring all of these potential issues to the attention of parents. Also recognise that some parents might notice behavioural changes in their child, but not be

attuned to the emotional underpinnings, in these instances explore further e.g. “How might your child be feeling that has led him/her to act that way”.

Give handout

Give handout “How children react to separation” and “Child Trauma Responses” and briefly go through relevant sections. Note to parents that the first handout is more specific to trauma-related fear symptoms (e.g. due to exposure to parental violence), whereas the second handout contains a range of reactions common in children post-separation.

For example explain some common reactions of children to traumatic experiences, and how they will present differently depending on their age and developmental stage – explain the role of developmental stage in a child’s cognitive development, their capacity to express and deal with difficult emotions, the presence or otherwise of other supports in their life, and coinciding developmental challenges.

Not all children will respond in the same way, and some may cope with the traumatic experience better than others. Each child is different. Work through the following list of examples.

Watch video

“Consider the Children” “Let’s have a look at a video that looks at some of the issues that children experience post separation and in particular the impact conflict can have.

Ask parents their reactions?

Summary of what the children are doing this week - Introduction to feelings identification/expression & “stinking thinking” (Give “stinking thinking,” “stinking thinking examples,” “Feelings identification & expression” and “Feeling Vocabulary Chart” handouts)

Feelings identification & expression

This week in their individual sessions the children are talking about feelings and how to identify them. The purpose of this is that many children find it difficult to understand what they are feeling, much less describe it. With an understanding of feelings, what they look like and feel like, we are helping children to make sense of what they are feeling (which can be frightening for them when extremes of emotion are experienced) and the tools to describe it. We are using visual aids (e.g. bear cards) to help the children identify feelings, and then exploring with them how that emotion might be felt in their own body. We are also sending the message that feelings are normal, it is how we respond to them that is important.

It would be useful for you to reinforce this learning by:

1) Labelling emotions for the child e.g. when you see the child looking angry, say “You seem to be feeling angry today”. This helps the child to match a feeling with how it feels. It also sends the message that you care and are in tune with the child, and opens up the channels for them to talk to you if they choose to.

2) Praise the child when they demonstrate that they have been able to recognise a feeling, and express it in an adaptive way e.g. when the child tells you they are feeling scared or miserable.

3) Understanding that you are a model for your child. If they see you identify your feelings and express them in an adaptive way, they learn that they should also manage their emotions in that way. (We will be covering this topic in later sessions)

[IMPORTANT: Spend time doing this]

Spend some time discussing the feelings of the group members in response to different situations, i.e., “When my ex-partner argues with me I feel.....” and “when my child misbehaves I feel.....”. Also explore with parents some adaptive ways of dealing with those emotions.

Introduction to stinking thinking”

We are also introducing the children to something called stinking thinking, which will be elaborated on with them in following weeks. This is an important part of the programme. We are presenting to the children the idea that how you think, directly affects how you feel. Provide an example to demonstrate this, e.g. the two scenarios of hearing a lamp falling off a table in your house when you are in bed, in one instance you have a cat, what do you think and feel? In the second scenario you don’t have a cat. What do you think and feel? In summary, bad thoughts lead to bad feelings, and one way to reduce bad feelings in the children is to target the way that they think. We are calling these bad thoughts stinking thinking.

Some of the stinking thinking we have observed in children who have been exposed to parental violence include: “It is my fault when mum & dad fight”; “It is my job to make mum and dad get along” and “My parents are not together anymore because I am bad”. Some parents will be surprised that their children might think this way, and you need to convey that children don’t think like adults, and they see the world in a much more egocentric way. It is not uncommon for children to have thoughts such as these, and to experience lowered self esteem, feelings of sadness, and frustration and disappointment in themselves when they can’t control the situation.

When you notice your child attributing responsibility to themselves for the fighting, or blaming themselves, you need to identify this as stinking thinking and together with the child think about a more realistic reason for what happened, e.g., “Mum and dad are adults and are responsible for our own behaviour. We both love you, and it is not your

fault when fights happen”. Ask the members to discuss examples of stinking thinking they’ve noticed in their child, and to think of better alternatives to these unhelpful thoughts.

Concluding the session

(Give out “Session Summary,” “Help for Children of Any Age,” and “War Zone Experiences” handouts).

To end today’s session on a positive note, have the parents take turns naming one specific behaviour that they want to see more of in their child. Encourage them to look out for it in the week ahead, and when they see it, to praise the child for that behaviour.

Finally, ask parents to say something positive about their child, something that they still appreciate about their child today. If any parent finds it really difficult to name even one thing, e.g., if they say that their child is just a brat, suggest that the child’s “bratty” behaviour can be a reaction to the difficult circumstances they have witnessed (in the parental separation), and that is a sign that the child has a degree of sensitivity. Sensitivity can be a strength—a positive—that’s important for developing close relationships with others. As far as possible, try to give a positive spin to what the parent might say. The point of this concluding exercise is to end the session (which has largely focused on problems and challenges!) on a positive note!

Homework

Activity for home (GIVE PARENT THE HANDOUT, “Parent Session Summary” and the handouts for homework”)

- 1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time
- 2) Assist the child with their homework—this week they have a worksheet where they have to record (writing or drawing) examples of stinking thinking in themselves. Parents need to help the child complete this worksheet as appropriate and bring it in for the next session (file it inside the parent’s folder).
- 3) Reinforce feelings identification and expression by labeling feelings, praising the child’s identification and adaptive expression of feelings, and modeling this yourself.
- 4) Look out for “stinking thinking” in your child, and when you notice it, let them know e.g. “I see some “stinking thinking” here. It makes you feel bad. What might be another way of thinking about this?”
- 5) Look out for “stinking thinking” in yourself too. When you have a negative thought ask yourself—Is this thought realistic? Is it flexible? Does it help me?
- 6) Read through the handouts given in session
- 7) Complete the handouts given for homework

**Parent Group – Session 2
Week 3 of program**

‘The Impact of the Conflict on my Child & What I Can Do’

Aims of this week

1. Continue to think about the impact of the parental conflict on the child
2. Learn how to provide security and stability, and how to improve their relationship with their child.
3. Learn about the relaxation techniques that their children learned this week.

Outline

- Outline of what this group is doing this week
- Review of rules and confidentiality agreement
- Review of homework and child’s progress re: target behaviour
- Providing stability and security
- ‘Improving my relationship with my child’
- Summary of what the children are doing this week - Introduction to relaxation strategies—diaphragmatic breathing and
- progressive muscle relaxation
- Homework

Materials

- Nametags
- A whiteboard or butcher paper and markers
- The ‘Children in Focus’ video
- 1 worksheet (‘Homework: Improving Parent-Child Relationship’) and 5 handouts (‘Providing Stability and Security for My Child’, ‘Children – Thinking, Feeling, Hearing’, ‘Improving the Quality of the Parent-Child Relationship’, ‘Relaxation Techniques’ and Parent Session Summary)

Outline of what this group is doing this week

Introduce the topic and what will be done for the next 2 hours

Review of rules and confidentiality agreement

Handout a typed up copy of the rules that participants developed last week. Briefly review them

Review of child's homework and progress re: target behaviour

Go through systematically each of their homework tasks for last week

Last week's homework tasks:

1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time

2) Assist the child with their homework—this week they have a worksheet where they have to record (writing or drawing) examples of stinking thinking in themselves. Parents need to help the child complete this worksheet as appropriate and bring it in for the next session (file it inside the parent's folder).

3) Reinforce feelings identification and expression by labelling feelings, praising the child's identification and adaptive expression of feelings, and by modelling this yourself.

4) Look out for 'stinking thinking' in your child, and when you notice it, let them know e.g. "I see some 'stinking thinking' here. It makes you feel bad. What might be another way of thinking about this?"

5) Look out for 'stinking thinking' in yourself too. When you have a negative thought ask yourself—Is this thought realistic? Is it flexible? Does it help me?

6) Read through the handouts given in session

7) Complete the handouts given for homework

Providing stability and security

Last week we worked on understanding the child's experience, this week we will look at ways that the parent can help the child to function better.

The parents brought their children to the programme because of worries about the child's fear response to the conflict they witnessed, and because they were not functioning as well as they might. It is clear that the children are experiencing a range of difficult emotions, notably fear, worry, uncertainty and insecurity. What they need so that they can start to process these feelings and gain some mastery over them, is a sense of security and stability. This is very important, and might be difficult to manage as the parent's lives have changed following the separation.

Brainstorm with the parents, the ways that they think they can provide the child with a sense of security and stability (write up on whiteboard).

Parents can provide this by:

- Maintaining routines (however be careful with this one because it is ok if each household has different routines – children do adapt – as long as they know what to expect from each household),
- Making sure that as little change happens as possible (but be realistic about this, sometimes people do have to move house or schools etc). Try and make sure they maintain contact with their old friends and family.
- Showing the child that they are coping (the child needs to feel that somebody is in
- Control), if the parent feels out of control, they need to actively seek support from friends and family
- Being consistent in their interactions with the child,
- Reassuring them that whilst you and your ex-partner have separated both of you still love the child
- Not putting down (–bad-mouthing”) the other parent
- Keeping conflict away from the child

Refer to the homework handout from last week –Children – Stinking Thinking, feeling, hearing.

The parent must never rely on their child for emotional support. Young children are not emotionally or cognitively equipped to provide you with that type of support, and need the space to be a child and adapt to the significant changes in their family life.

The key words here are *stability* and *security*.

Improving my relationship with my child

Research has shown that if a child has at least one supportive and close relationship with an adult, they are less likely to experience a range of difficulties, including psychological disturbance (of course, it is most optimal to have a loving relationship with *both* parents). This is not to say that the parents are not close with and supportive of their children, but improving this relationship can't hurt. Often when parents have been through conflict and a separation process, they have had less time and head space to devote to their children. This is understandable. It is however, relatively simple to make significant changes in the quality of their relationship with their child, and it is likely to have positive effects for both the child and the parent.

We are going to talk about some techniques that you can use to not only help your relationship with your child but parents often find that by putting these things in place can improve children's behaviour and adjustment

Family Fun Time

Doing this with your children will increase positive and warm contact with your children. It is doing a fun family activity together'.

Give out handout and go through it with participants.

So when you get home talk to the children about this concept and together decide on when it will happen and what you will do?'

One-on-one time

This is powerful stuff!! This activity helps to increase your children's self-esteem and meets some of their emotional needs, including feeling accepted. One-on-one time is REGULAR, SHORT times that parents spend with their children. It is a time where children can feel that everything they do is right and nothing they do is wrong. After separation parents are so busy that this time can get overlooked. But it is crucial at this time that children have exclusive time with their parents and receive attention and emotional support.

Before beginning, announce to your child that you are doing some one-on-one time.

Practise the skill of tailgating - verbally commenting on what your child is doing. Imagine that you are commentating a sporting event. Simply narrate, do not judge what your child is doing. This is a time to show positive acceptance. You may need to tailor this for older kids they don't particularly like you 'tailgating them', but they do appreciate you spending the time with them. With older kids it is usually just talking about what matters to them.

Give out handout

How do you think it would feel for the child????

Obtain responses such as special, important.

How do you think it would feel to be Mum????

Some mums might feel awkward- let them know it gets easier with time. Some mum's might feel like they are spoiling their child or indulging them. Reinforce to them that it is really important that their child feels special and important at this time. Their children can't get enough of your positive attention at this time.

Trouble-shooting One-on-One Time

Ask participants _what might get in the way of one-on-one time?‘

If child misbehaves during one-on-one time do what you normally would do after this type of behaviour and reschedule one-on-one time for the next day or so. (Ideas on discipline will begin next week).

If your other children try to interrupt one-on-one time let them know you will spend one-on-one time with them at a specified time. Try and do one on one time when your other children are occupied. Be fair with one-on-one time and make sure you give each child the same amount of time.

If your child does not want to do it tell them that this is really important for you to stay connected with them. Let them know it is easy for families to drift apart when there are so many changes. →just really want to spend some time with you. Will you give it a try?”

If your child does not want one on one time to end, empathise with them that you understand that it is difficult to stop when you are having a good time. Let your child know when the next one-on-one time is so they can look forward to it.

If some people talk about lack of time let them know that this is a common concern but ask them what is more important than the emotional development of their child. Some people talk about not worrying about their houses being so clean. If necessary shorten the one-on-one time to 5 to 10 minutes.

Remember this is a time NOT to direct your child or teach them anything!!

Catch them being good

Catch them being good is pretty self-explanatory and helps to reduce the escalation cycle. Talk about escalation cycles and how you can stop them. Ask them if they have had the experience that it doesn't matter how much you yell, they just don't seem to listen and will often get naughtier!!!! Inform them that this is the escalation trap. The louder you get the naughtier they get. Children will learn that to get attention they just need to muck up!

This skill will help your child build their self-esteem and also enhance the chance of your child continuing with their good behaviour.

Give out handout.

Listening, Thinking and Responding

Learn to listen!!!

Children really want to talk to their parents. Children really want their parents to listen to them. Listening is not about giving advice or fixing things. We need to get out of that habit. Listening to your children will allow you to feel closer to your children and will help your children figure for themselves what to do. This will give them confidence and mastery. Listening involves:

1. Listening
2. Thinking
3. Responding

We are going to look at each of these 3 skills separately!!!

Give participants the handout and go through each of the 5 listen to me skills.

Do an exercise with the participants where they can put together the 5 talk-to-me's together. Get into pairs. Have one member talk about their previous weekend while the other member practises their 5 talk-to-me's. Keep the OHP up while the participants practise. Remember to reinforce the participants efforts. How do you think your child will feel if you do this?

Give out the next handout

Remember good listening isn't easy and requires time and patience and practise!!! Remember that you don't feel that you have to listen whenever your child requests it. You may be busy or it might be inconvenient for you. When this occurs, smile at your child and give them your attention while saying, 'I am really interested to hear what you say, but I am doing now. How about we have some one-on-one time in(e.g., 1 hour) and you can tell me all about it then'. Maybe even end the statement with some physical contact. A quick kiss or a touch on the head etc.

Thinking

How often do we reply to our children without really thinking about what their request is or what we are saying?

We want to teach you to think before responding – consciously thinking – stopping and thinking!!! This will allow you time to tailor your responses to your children's needs. Stopping and thinking will stop you going into automatic pilot mode and replying with a 'quick fix'. It will take some practise because we are not used to doing it!!

What generally happens when you rush into a response? (miss important info, feel frustrated, children feel frustrated, give advice when not needed).

When you are thinking, think - Can you use the 5 listening skills or does your child need some guiding.

Responding

When you respond start by summarising what your child has said or summarise how they are feeling!! This can be a bit tricky, particularly about the feelings bit. After the child has finished telling you their story briefly summarise what they have said. If there is an emotion attached to it, summarise that. E.g., 'hmm, lets see if I got this right, you went over to your Mum's place and you said that you had a fight with her and that seems to have made you feel upset'. Give out feeling hand-out.

Minimal guidance – sometimes children will ask you what to do. In this instance guide them to developing their own responses. Maybe say back to them, 'what do you think you could do', or 'have you thought about doing'. Always finish the conversation with 'I really appreciate you being able to talk to me like this'.

Trouble-shooting – Listen, Think, Respond

Identify when it is hard to use your listening skills.

Ask participants this question and try to generate the following responses.

1. when busy – postpone listening
2. lightning bolt issues/questions

When you find yourself not using your new parenting skills that will become a part of your permanent parenting style, think, what made it hard not to use my skills e.g., 'I got really angry', 'my child is particularly naughty', 'I am feeling really tired or busy'. Then think what problem must I solve e.g., need to understand why my child is being naughty by using listen, think, respond or one-on-one time, or maybe I need to have a sleep and communicate this to my child e.g., 'Mummy is feeling really tired and not very patient, I

am sorry for this. I will have a little sleep and then I will feel better and will be able to spend some one-on-one time with you.'

The Lightning Bolt Questions

Parents generally have one big concern when they are talking about listening, thinking and responding and it involves the lightning bolt questions. This is where children talk to their parents about issues which the parents are afraid to bring up with the children – hence the lightning bolt question.

Give these examples of some common Lightning Bolt Questions (which might be the same for the participants). If time permits brainstorm how they might be dealt with – otherwise have them do this for homework.

Give out handout

Reason's for Parents Separation

Be age appropriate. A lot of parents talk about how they always tell the truth and their children deserve to know the truth. This is not always best for your children. And it is not fair to impose your sense of morality if it means you are actually going to hurt your children. We recommend that children be told four messages about the divorce:

1. A simple statement that the marriage didn't work – 'We tried very hard but we couldn't make our marriage work'.
2. A message that you still love your child – 'I don't love your Mum anymore, but I love you as much as always and I will always love you. Children don't get divorced. You still belong to both of us'.
3. Reassurance that the divorce wasn't the child's fault – 'Nothing you have done or could've done affected our decision'.
4. Reassurance about the future – 'I'm never going to leave you or stop loving you. I'll always be there for you'.

With the lightning bolt questions you might need to say it over and over again (possibly every week). Unlike adults, children don't necessarily understand or integrate the message if it is said only once.

New Partners

Most children's fears about new partners are related to feelings that they might lose the parents love or have to compete for attention. It is important to listen, think, and respond to children at this time!!! Be empathic about how they might be feeling.

Summary of what the children are doing this week

This week the children are getting together as a group. The purpose of this is that they are able to see that other children are in similar situations. They will talk about unpleasant feelings and what they do to cope with them, and will be sharing their ideas. They will talk a little more about feelings, working on feelings identification and expression.

The children then go on to learn some other ways that they can help themselves feel more calm and relaxed when they experience such feelings as fear, worry and anger. They will learn some relaxation strategies, which can be used anywhere at any time.

Relaxation Techniques(Week 3 Parent Handout 4)

Relaxation—diaphragmatic or ‘calm’ breathing

Children are taught how to breathe deeply and slowly, to slow their heart rate and calm their bodies down, so that they can exercise some control over unpleasant feelings.

Show the parents how the children were taught the skill.

e.g. —This type of breathing is different to normal breathing. Let me show you how it goes. When I breathe in, I start the breath from right down in my tummy, and I breathe in slowly. Like this. (With your hand on your stomach, give an example of a slow, diaphragmatic intake of breath). Then you let the breath out very slowly, like this. You need to make sure that your breaths start from way down in your stomach, not from up here in your chest.

Now let's all try together. Put your hand on your stomach so you can feel it move, and slowly breathe in, then breathe out even more slowly (do this at least 10 times). You can imagine you are breathing in good thoughts with the clean air, and breathing out your worries. You can try saying slowly to yourself the word ‘calm’ as you breathe out. Do you feel any changes in your body?

I want you to practise this breathing everyday. You can choose when, but make it a time when you can concentrate, like just before bed. I want you to practise taking 20 deep breaths each time.”

Relaxation - progressive muscle relaxation or tighten and relax

This is a progressive muscle relaxation activity, to be used when the child feels worried or stressed and their muscles feel tight and sore. The idea behind the exercise is that when we relax our muscles, we feel calmer and more comfortable. This script is designed specifically to appeal to children, and the scenarios explained are easier to recall so the child can practise the technique at home/school. You could call it ~~“tighten & relax”~~. This script starts with the legs and feet as one muscle group, moves up to the shoulders and upper body as another muscle group, then to the arms and hands, finishing with the face. Using fewer muscle groups will make it easier for the child to recall the exercise. Show the parents how the children were taught the skill:

—This exercise is one where we tighten different parts of our body, then relax our muscles. I will talk you through it. Sit back in your chair and get as comfortable as you can, put both feet flat on the ground and let your arms hang loose by your sides. Now close your eyes, and don't open them until I say to. Pretend you are in a big barrel full of grapes, and you are squashing the grapes with your feet to get the juice out. It is hard work; you will need to use your legs to help you push down. Feel the grapes under your feet and between your toes, squash, squash, squash as hard as you can. Now relax your feet, let your ankles and toes go loose. They feel all nice and relaxed. Now back to the grapes, squashing down, down, down through your feet. Let's get all of that juice out. And relax again. Feel your toes, feet and legs relax. They don't feel stiff at all.

Now pretend that you are standing under a big tree, and you are reaching up with both arms, trying to get your ball which is stuck in the branches. Stretch up high with both arms, as high as you can, you can nearly touch the ball. Then drop them to your sides. Can you feel your shoulder muscles relax? Ok, let's give this another go, the ball is nearly within your reach. Lift both of your arms high over your head, stretch, stretch, stretch—you have almost touched the ball. Stretch just a little bit further. Then drop them to your sides again, and feel the muscles loosen and relax.

Now pretend that you have a big orange in each of your hands. You need to squeeze both hands very tight, you are trying to squeeze all of the juice out of these oranges. Can you feel the tightness in your hands and arms as you squeeze? Now drop the oranges to the floor, and feel your muscles relax. Grab two more oranges, one in each hand, and squeeze them even harder this time, we want every drop of juice out. Squeeze, squeeze, squeeze. Feel how tight your muscles are. Then drop the oranges to the ground, and feel your hands and arms relax.

Now let's pretend that there is a little beetle crawling on your face, but you can't swat it away with your hands. Try and get the beetle off your face without using your hands. Screw up your nose, and scrunch up your face. That's the way. Get that beetle off. Now relax your face and nose. Oh no, here he comes again. Wrinkle up your nose again, and scrunch up your face. Hold it as tight as you can. Scrunch, scrunch, scrunch. Can you

feel your cheeks and forehead all tight? Now, relax your face and nose, let those muscles lose all of the tightness, your face smoothes out, and feel the rest of your body relax too. Now you know what it feels like to have tight muscles, and also what it feels like to have loose, relaxed muscles. Whenever you feel that you have tight muscles, like in your shoulders or face, you can do these exercises to relax them and help you be calm.”

Homework

Give out 2 homework handouts and ask to them to complete it and bring it in next week. Let them know there is quite a bit of homework this week to do.

Activity for home (GIVE PARENT THE HANDOUT, –Parent Session Summary”)

1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time

2) Assist the child with their homework—practising the calm breathing and muscle relaxation strategies daily. The children have been given two worksheets where they are required to log the date and times they practised these skills. On the worksheet for muscle relaxation, the child has to rate their level of tension from 1 (*very relaxed*) to 10 (*really tense/anxious*). Parents are to ensure that the child practises these strategies twice a day and help them complete the worksheets. File the completed worksheets in the parent folder and bring in for next week’s session.

3) Work on improving your relationship with your child by using the strategies discussed earlier commit yourself to at least 2 of these ideas, however the more the better. Fill in the Improving relationship homework handout

4) Continue to reinforce feelings identification and expression by labelling feelings, praising the child’s identification and adaptive expression of feelings, and modelling this yourself.

5) Continue to look out for stinking thinking in your child, and when you notice it, let them know, e.g. –I see some stinking thinking here. It makes you feel bad. What might be another way of thinking about this”?

Week 4
Group Session 3

Reducing the Conflict – How Can I Communicate with My Ex-Partner?

The goals of today's session are to think about ways that the parent attending the programme can work towards minimising the child's exposure to conflict. These ways include communicating more effectively, being more aware of their own and their ex-partners' triggers to anger and conflict styles, and effective problem solving in the face of challenging situations.

Outline

- Outline of what this group is doing this week
- Review of confidentiality agreement
- Review of child's homework and progress re: target behaviour
- Thinking about how the parent can minimise their child's exposure to the conflict
- Conflict reduction and communications skills training
- Self-regulation—my triggers and conflict style
- Summary of what the children are doing this week
 - Exposure—the purpose, the method, and how the child might respond
- Homework

Materials

- Nametags (if necessary)
- DVD- "Children in Focus" (20 minutes)
- A whiteboard or butcher paper and markers
- 1 worksheet ("Homework: Improving Parent-Child Relationship") and 6 handouts ("Communication Skills", "Assertive Behaviour", "Self-Regulation and Problem-Solving Skills", "Exposure", "More on Stinking Thinking 1" and Parent Session Summary)

Outline of the session

Summarise what you will be focusing on in the session today.

Review of homework, child's progress re: target behaviour and general functioning

Their homework for last week was:

- 1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time
- 2) Assist the child with their homework—practising the calm breathing and muscle relaxation strategies daily. The children have been given two worksheets where they are required to log the date and times they practised these skills. On the worksheet for muscle relaxation, the child has to rate their level of tension from 1 (*very relaxed*) to 10 (*really tense/anxious*). Parents are to ensure that the child practises these strategies twice a day and help them complete the worksheets. File the completed worksheets in the parent folder and bring in for next week's session.
- 3) Work on improving your relationship with your child by using the strategies discussed earlier commit yourself to at least 2 of these ideas, however the more the better. Fill in the Improving relationship homework handout
- 4) Continue to reinforce feelings identification and expression by labelling feelings, praising the child's identification and adaptive expression of feelings, and modelling this yourself.
- 5) Continue to look out for stinking thinking in your child, and when you notice it, let them know, e.g. "I see some stinking thinking here. It makes you feel bad. What might be another way of thinking about this"?

Minimising the child's exposure to parental conflict

DVD: —Children in Focus”

Watch the DVD. Obtain parents reactions.

General discussion points to consider

Discuss with them the importance of reducing their conflict. Discuss the impact of children who witness their parents ongoing conflict. Children feel very reassured when they witness their parents talking about taking care of them. What do you think children would experience if they continually see their parents argue? How might this affect their development emotionally? What might it be like for your children if conflict was reduced?

As discussed in the group over the past few weeks, the impact on children of being exposed to parental conflict or violence is significant. In this part of the session, the focus needs to be on discussing ways that the parents can minimise their child's exposure to conflict. It also needs to be conveyed that you don't expect miracles; one party alone can NOT act to stop all conflict. This is more about limiting the child's exposure to it, and where possible minimising it for the benefit of both parents also.

Why is this important?

The child needs to feel secure and safe, and parental conflict retracts from that. Moreover, the child has already been traumatised by the parental conflict, and is suffering from that, so further exposure to fighting is going to compound their difficulties.

The group needs to make a commitment to making their child's wellbeing paramount. It is more important than a moment of frustration, or needing to have the last word in a fight. They need to understand that they can make a difference in this respect, but that it will take self-control.

There are some skills that the group will be learning this week that can help minimise conflict—namely how they can better communicate with their ex-partner, understanding their own triggers to conflict and conflict style (and those of their partner), and how to problem solve.

Different parenting relationships post separation and impact of parenting relationships on children

Hand out to participants descriptions of the different types of post separation parenting relationships and have participants work out which best describes their relationship with their former partner?

- Cooperative
- Parallel
- Conflictual

Also discuss the different conflict styles

Some people avoid the situation by leaving or withdrawing from the situation

Some people are forceful; they try to control the situation and try to win at all costs

Some people are accommodating; they ignore their own goals to smooth things over

Some people are compromising; they try to meet the other person halfway, both parties sacrifice part of their goal.

Some people are collaborative; they use problem solving skills to find a solution that is agreeable to all.

Reducing the Conflict

Identify when you are most likely to have conflict?

How do your children respond to being caught in the war zone (from homework)?

Ask, what gets in the way of you communicating with your ex? What can you do about it?

Let's think of some ways to reduce the conflict

Give handout Reduce the Conflict Discuss

Give out handout Communication Skills Discuss

Anger Management - Coping Self Statements and Assertion

As well as rapid relaxation lets discuss coping self-statements which is used as a form of anger management and will help you to reduce the conflict with your ex.

Give out anger management handout.

If time, give out ‘Assertive Behaviour’ handout and ‘coping self statements’ handout

Ask them to write down an assertive statement?

Remind participants about the need to be assertive with other people other than your ex in relation to the separation!!!! For example, family members may put-down your ex to your children. An appropriate assertive response using an I-Statement to them might be something like:

“I know you are trying to be on my side and support me, but when my daughter hears you say bad things about her dad, she feels really bad. So please for her sake stop saying these things when she is around.”

Summary of what the children are doing this week in their individual session

(REFER PARENT TO HANDOUT, ‘Exposure’)

Exposure

(Week 4 Parent handout 4)

The children begin exposure in this week’s individual session. Whilst the parents are aware that exposure is a critical part of the programme, there is likely to be some anxiety around it, and further discussion on the process, why it is used, and how they can best support their child will be useful.

The children have been referred to the programme because they have been exposed to a traumatic experience, and they are presenting with symptoms of fear/anxiety, particularly to reminders or memories of the trauma. The feared memories generate significant distress for the child, and if the child’s fear reaction does not fade naturally, the child may try to control the symptoms by using unhealthy patterns of avoidance. Avoidance can have a significant impact on the day to day functioning of the child, and when severe can impact upon the child’s normal development.

An important step in the treatment of trauma related fear reactions is to teach children ways of managing their fear that are more adaptive than avoidance. By exposing the child to the feared memories, they discover that they will not be overwhelmed by the memories and be unable to deal with them; in fact, they will gain practice in dealing with these intense emotions. Moreover, through exposure children are able to make attempts at

understanding their experience and integrating it into their world view; their distorted cognitions are exposed and able to be challenged; and ultimately the child's level of anxiety (emotional and physiological) relating to the trauma naturally habituates with its retelling.

The idea of directly discussing the child's traumatic experience may seem counter therapeutic to some ways of thinking, however the goal of exposure is to break down the associations between a range of thoughts, reminders or discussions of the trauma and overwhelming negative emotions. Without exposure, the fears are not confronted and dealt with.

The safety and wellbeing of the child is paramount at all times, and the therapist treating the child is trained to deliver this therapy. The therapist will be monitoring the child's level of distress (subjective and objective) throughout the session to ensure that they are coping, and will adapt the treatment accordingly. The child will be supported and encouraged throughout the exposure process.

The child has also been taught skills at emotion regulation (calm breathing and muscle relaxation) that they can use should they become extremely distressed during the process, with the fear not apparently habituating.

How the child might respond

There is no one way that a child will respond to exposure. It is a challenging process, and children are thinking and talking about distressing memories, so it is likely that they will struggle somewhat in the ensuing days. You might notice regressed behaviour (behaviour of a younger child), they may be distracted, they may misbehave a bit more, they may be more fractious. All children respond differently. These are temporary behavioural responses, and should pass after a few days.

The parent can support their child by understanding that the exposure is difficult and overlooking/forgiving trivial misbehaviour. Instead, they should catch them being good more often, and spend more one-on-one time with them. They should also make a special effort to let the child know that they are there for them, and be conscious that the child needs security and stability at this time in particular. Practising relaxation skills with the child will also be useful.

What the children are doing this week in their group session

REFER PARENT TO HANDOUT –More on Stinking Thinking 1”

More on Stinking Thinking 1 (Week 4 Parent handout 5)

Stinking thinking was first introduced to you and the kids in week 2. Within their small groups this week (and the next two weeks), the children will be learning a bit more about stinking thinking, and doing some activities to help them (1) see how thoughts directly impact on their feelings, and (2) to identify what would be stinking thinking vs good thoughts. The following is the scenario used this week:

Scenario 1 (general)

A girl called Sally is new to her school, she has been there about a month, and she has made some new friends. One day she sees one of her new friends in the playground and starts to walk over to talk to her. The other girl started walking in the opposite direction, and when Sally yelled out to the girl, she didn't turn around or reply.

Questions:

- What might Sally be feeling? What do you think Sally is thinking to feel this way? What might she do in this situation?
- What are some other examples of how Sally might be thinking?

The children will discuss as a group which examples are stinking thinking and which are OK thoughts.

The therapist will draw the children's attention to the fact that in the previous activity, even though the situation was the same, they could come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it. Our thinking only becomes stinking if the thoughts make us feel bad and aren't necessarily true. Stinking thinking makes us feel bad, and that is why we say it stinks—the thoughts make the child feel bad, when there might be another more helpful way of looking at the situation.

Parents need to pay particular attention to thoughts around the child being responsible for the conflict and that they should be able to control it, as these are common themes among kids exposed to parental conflict/violence. When you notice stinking thinking you can say to your child, e.g. “I see some stinking thinking here. It makes you feel bad. What might be another way of thinking about this”?

Homework

Activity for home (*GIVE PARENT THE HANDOUT, ~~Parent~~ Session Summary*)

- 1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time
- 2) Assist the child with their homework – they have earned a small reward this week for beginning and doing well with the exposure
- 3) Practise using the tips discussed in today’s session (cf handouts ~~Communication Skills~~, ~~Assertive Behaviour~~ and ~~Self-Regulation and Problem-Solving Skills~~) when communicating with your child’s other parent to reduce conflict with him/her. Fill in the homework worksheet.
- 4) Continue to work on improving the quality of your relationship with the child (*USING WEEK 3 HANDOUT AND WEEK 4 HOMEWORK WORKSHEET ~~Improving Parent-Child Relationship~~ PROVIDED*). This is an ongoing task which will reap rewards for you and your child. (Susie) – e.g., catch them being good, one on one time, family fun time
- 5) Continue to assist the child with their homework—practising the relaxation strategies each day, and identifying and challenging their stinking thinking whenever it arises.
- 6) Support your child following the exposure as outlined in handout, ~~Exposure~~.

Week 5
Group Session 4

Collaborative Coparenting

Making Co-Parenting Work Better

The goals of today's session are to think about ways to break down barriers to cooperative parenting.

Outline

- Review of confidentiality agreement
- Outline of what this group is doing this week
- Review of child's homework and progress re: target behaviour
- Building a parenting coalition
- Troubleshooting
- Supporting your child's relationship with your ex
- Summary of what the children are doing this week
 - Exposure with challenging & future planning
- Homework

Materials

- A whiteboard or butcher paper and markers
- worksheets
- handouts
- prepare the over head projector

Review of homework, child's progress re: target behaviour and general functioning

- 1) Sit down with your child and allow them to explain to you what they did in their session this week, at the designated time
- 2) Assist your child with their homework—practising the relaxation strategies each day, and identifying and challenging their 'stinking thinking' whenever it arises. Support your child following the exposure this week by following the suggestions outlined in the Exposure handout. They have earned a small reward for beginning and doing well with the exposure
- 3) Practise using the tips discussed in today's session (refer to this week's handouts) when communicating with your child's other parent. Fill in homework worksheet.

- 4) Continue to work on improving the quality of your relationship with the child (use Week 3 handout and worksheet provided). This is an ongoing task which will reap rewards for you and your child e.g., catch them being good, one on one time, family fun time.

Building a parenting coalition

Give out the handout ‘_Parenting Coalition’ and work through it with the participants.

Troubleshooting

Let’s talk about some common impediments to collaborative co-parenting. Put up the over head projector and discuss each one of the problems(use the handout to generate ideas). After the discussion has finished give out the handout.

Supporting your children’s relationship with your ex

Research shows that children who have regular ongoing contact with both parents do the best!!! In this section it is important to illicit participant’s barriers to helping their children with their relationship with the other parent. Use gentle challenging and reflect the impact on children.

Ask them about the child’s relationship with the other parent before the separation?

Did they allow the child to be alone with the parent prior to the separation?

Be careful though because sometimes contact can be dangerous for the children.

Ask participants how they currently support their child's relationship with the other parent? (regardless of what the quality of the relationship with the other parent is like).

Write answers up on the board.

Give out hand out Supporting my child's relationship with the other parent.

Give handout Are there things I do that Restrict their Relationship?

Depending on the group you may like to get people's reactions to this. But be prepared for some defensiveness.

Summary of what the children are doing this week in their individual session

Further exposure with challenging

The children will continue with the exposure work discussed in last week's session; however this week the therapist will also incorporate challenging of the child's stinking thinking. The goal of this session is to continue to expose the child to the feared memories, to weaken the fear response; and also to start correcting some of their faulty thinking. As the group has already discussed, stinking thinking leads to bad feelings. It is usually not a realistic thought, is typically inflexible, and there is usually a more helpful way to think about a situation.

What the children are doing this week in their group session

REFER PARENT TO HANDOUT ~~More on Stinking Thinking 2~~

More on Stinking Thinking 2
(Week 5 Parent handout 2)

Within their small groups this week, the children will continue to learn about stinking thinking. Like last week, they will do some activities to help them (1) see how thoughts directly impact on their feelings, and (2) to identify what would be stinking thinking vs good thoughts. The following are the scenarios used this week:

Scenario 2 (general)

Tom has just found out that he has failed a maths test at school. He usually does OK in tests, but maths is the subject he finds hardest.

Questions:

- What might Tom be feeling? What do you think Tom is thinking to feel this way? What might he do in this situation?
- What are some other examples of how Tom might be thinking?

Scenario 3 (specific)

Judy and her sister are very close, and care a lot about each other. Judy usually looks after her sister when she needs help, or when their parents aren't nearby. She likes to take care of her sister. Judy has just found out that her younger sister is unwell, and needs to go to hospital. Judy feels guilty.

Questions:

- ◆ We know what Judy is feeling in this situation; she is feeling guilty about her sister going into hospital? What do you think Judy is thinking to feel this way? What might she do in this situation?
- ◆ What are some other examples of how Judy could think about this situation?

The children will discuss as a group which examples are *'stinking thinking'* and which are ok thoughts.

The therapist will draw the children's attention to the fact that in the previous activity, even though the situation was the same, they could come up with some very different ways a person might feel about it, and that the way we feel depends on how we think about it. Our thinking only becomes stinking if the thoughts make us feel bad and aren't necessarily true. *'Stinking thinking'* makes us feel bad, and that is why we say it stinks—the thoughts make the child feel bad, when there might be another more helpful way of looking at the situation.

Parents need to pay particular attention to thoughts around the child being responsible for the conflict and that they should be able to control it, as these are common themes among kids exposed to parental conflict/violence. When you notice stinking thinking you can say to your child, e.g. "I see some *'stinking thinking'* here. It makes you feel bad. What might be another way of thinking about this"?

This week the children have been asked to identify one example of stinking thinking in themselves, to discuss in next week's small group session. Parents can assist with this task.

Activity for home (*GIVE PARENT THE HANDOUT, –Parent Session Summary*)

- 1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time
- 2) Assist the child with their homework at the designated time
- 3) Support your child following the exposure as per last week.

- 4) Complete the ~~“Improving the parenting relationship and supporting your children”~~ handout.
- 5) Continue to work on improving the quality of your relationship with the child (*USE WEEK 3 HANDOUT2 ~~“Improving Parent-Child Relationship”~~* e.g. one on one time, family fun time, catch them being good, listen, think, respond ect....
- 6) Continue to assist the child with their homework—practising the relaxation strategies each day, and identifying and challenging their stinking thinking whenever it arises. The child needs to bring one example of stinking thinking to the session next week.

Week 6
Parenting Group Session 5

Parenting after Separation – Love and Discipline

In this session there is a lot of content. You may want to sit down with your co-facilitator and work out what you will cover. There are many handouts that you could provide them for homework.

Outline

- Outline of what this group is doing this week
- Review of confidentiality agreement
- Review of child's homework and progress re: target behaviour
- Parenting Styles
- Discipline Plans
- Summary of what the children are doing this week
 - Exposure with challenging & future planning
- Homework
- The Future – support from each other

Materials

- A whiteboard or butcher paper and markers
- worksheets
- handouts and Parent Session Summary
- OHP

Review of homework

1. Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time
2. Assist the child with their homework at the designated time
3. Support your child following the exposure as per last week.
4. Complete the ~~–Improving the parenting relationship and supporting your children~~” handout.
5. Continue to work on improving the quality of your relationship with the child (*USE WEEK 3 HANDOUT2 –Improving Parent-Child Relationship*” e.g. one on one time, family fun time, catch them being good, listen, think, respond ect....

6. Continue to assist the child with their homework—practicing the relaxation strategies each day, and identifying and challenging their ‘stinking thinking’ whenever it arises. The child needs to bring one example of ‘stinking thinking’ to the session next week.

Parenting Styles

Discuss the following with the participants.

Discipline is about teaching not punishment!

Discipline presents a big challenge for single parents. Ask the participants why this might be? (only one parent rather than two, divorce causes lots of stress which impact negatively on parents and children, children do tend to behave more poorly given the stressors, less time to supervise).

So after separation parents have less help with discipline and more complex discipline problems. Parents often expect higher standards from their children and to take on more responsibility. This all sounds a little contradictory!!!

Discuss the different parenting styles – give out handout “Identifying your own parenting style”.

Have participants work out which one they are and which one their former partner is?

Discipline

Your discipline has a big effect on the nature and quality of the relationship you have with your children. We want to try and increase your democratic parenting practises.

Why do children misbehave?

Ask participants why they think their children misbehave. Try and generate the following responses (write them on the board):

Children misbehave not because they are bad or punishing you for the separation. They misbehave because:

- Not getting enough positive attention (tackle this by using one-on-one time, catch them being good)
- They may be angry and expressing their feelings by ‘acting out’. They may do this because they are unsure how to express themselves appropriately and are unsure how else to make themselves heard (tackle this by using listen – 5 listening skills, think, respond).
- They are not clear about what the rules or expectations are and will ‘test the limits’. Also they misbehave because sometimes they think they can get away with it.

Developing a Discipline Plan

Give out handout. Tell participants we are going to cover these (particularly the first 2 in some detail).

1. Adopting clear and realistic expectations

Expectations are standards or guidelines for behaviours. They convey to kids what they should or should not do. Children need clear, specific expectations so they know what you want from them. Kids want to be good but they need to know what behaviours are acceptable and not acceptable. Also expectations should be realistic – be age specific. It is not fair to think a 5 year old should be quiet all the time or do the laundry.

As the parent you need to set these expectations.

Be specific – ‘my child should stop being bad’ is not very specific. You need to be clear in terms of what are the specific behaviours that my child does that makes them bad. E.g., not getting out of bed on time, teasing the dog, not doing the washing up, talks back to me when I ask them to do something.

Let’s have a go at setting some specific, realistic expectations.
(have parents write some expectations and then read aloud for all members to discuss and evaluate). Some parents need a bit of help with this.

2. Developing a Change Plan

Every time your child meets an expectation or fails to meet an expectation you must respond.

Give attention every time they meet the expectation (compliment, thank you, special privilege). This is by far the easiest way to get your kids to meet the expectations!!!! Use it all the time!!! It doesn’t take much time or effort, but it will pay off!!

When children fail to meet an expectation you need to respond. We will discuss a number of options for how to respond – give out handout.

Some parents ask about spanking. Most parents use spanking when they are angry. We recommend that you do not spank your children. There are far more effective ways of punishment. Spanking is physical violence. We think it’s a bad message to teach your children that physical violence is sometimes ok. If you choose to spank please think very carefully about it and never, never do it when you are angry!!

What kind of unpleasant consequences would work for your children e.g., washing up, coming home early????

When using negative consequences describe the behaviour that you don’t like rather than the child. For instance tell the child, I do not like it when you tease your sister, rather than you are a bad person for teasing your sister.

Give out handouts

Children will continue to test you. Even when you think you have a behaviour in check, children will test you out just to make sure. Remember stay calm and be consistent in your plan.

You need to make sure you are consistent in both providing positive consequences when your child meets the expectations and negative consequences for when your child does not. If you are consistent your children will take you seriously and reduce arguments and negotiation attempts.

Try to limit your expectations. Manage only those behaviours which are important enough to you to be specific about, attend to, and consistently reward and punish.

Often your mood can get in the way of providing discipline. Research shows that stressed parents use harsher and inconsistent punishment. This as we know does not teach your children about good behaviour and is likely to lead to your children behaving even worse. Let your children know ahead of time that you in a bad mood because of xyz e.g, a bad day at work. Do not say you are in a bad mood because of the other parent. This will keep your child from feeling guilty or thinking that they have done something wrong if you need to take some time out for yourself. Have a bath or a quite coffee. Dinner can wait 10 minutes. Use your anger management skills e.g, self-coping statements I don't need to lose it at my child's bad behaviour.

Acknowledge that discipline is hard but it teaches children valuable lessons that will hold them in good stead throughout their development. Remember though when implementing any new discipline plan, some of your children's behaviour may get worse before it gets better. This is because some children may test the limits and buck at the new system. But be patient and remember that you will have long term gain.

Shaping

Sometimes children may not always get it exactly right. Shaping is rewarding small approximations toward the final goal. For example your 11 year old irons her shirt but still leaves creases in it. Do not point out the creases but praise her for ironing her shirt. Your 6 year old son puts his socks in the dirty clothes basket but leaves his shirt on the bathroom floor. Praise putting his socks in the basket. Next time he leaves his shirt on the floor simply remind him. Shaping is a really good skill to help children learn a new behaviour.

Tell the participants that for lots of children the expectations and rules can change between each household. Reinforce to them that this is not the end of the world. Children can cope quite ok with this. As long as they know what the rules are for each household. E.g., at Mum's house they bath before dinner, at Dad's house they bath after dinner.

Summary of what the children are doing this week in their individual session

Exposure with challenging- This is a continuation of last week's session.

Future planning

The children will also be thinking about a future situation that they feel scared about, such as when both parents will meet next for a handover of the child. They will be thinking about what they can do in that situation to manage their fear/bad feelings. The children will be encouraged to use the skills taught over the past few weeks including relaxation strategies to calm themselves, challenging their *'stinking thinking'* about the situation, e.g. *'it is not my fault if they fight'*, and using assertive behaviours to minimise their exposure to the distressing situation, e.g., going to sit in the car if fighting happens, or reading a book in another room of the house.

What the children are doing this week in their group session

REFER PARENT TO HANDOUT –More on Stinking Thinking 3'

More on *'Stinking Thinking'* 3

(Week 6 Parent handout 6)

This week will be the last time the kids are gathered together in their small groups. They will continue to learn about *'stinking thinking'*, doing some activities to help them (1) see how thoughts directly impact on their feelings, and (2) to identify what would be *'stinking thinking'* vs good thoughts. The following is the scenario used this week:

Scenario 4 (specific)

It is Harry's birthday on the weekend coming up and he is having two of his best friends over to play. One of these friends is Harry's neighbour; the other friend is a boy from school. These two boys don't know each other very well, but they always fight when they play together. Harry is starting to feel worried and is laying awake at night thinking of ways that he can make his friends get along.

Questions:

- We know what Harry is feeling in this situation, he is feeling worried about his friends fighting. We also know what he is going to do in this situation, he is spending his time worrying and thinking about what he can do to make them get along. What do you think Tom is thinking to feel this way? (*that it is his responsibility that his friends get along*).
- What are some other examples of how Tom could think about this situation?

Like previous weeks, the children will discuss as a group which examples are *'stinking thinking'* and which are ok thoughts. The therapist will draw the children's attention to the fact that in the previous activity, even though the situation was the same, they could come up with some very different ways a person might feel about it, and that the way we

feel depends on how we think about it. Our thinking only becomes stinking if the thoughts make us feel bad and aren't necessarily true. *'Stinking thinking'* makes us feel bad, and that is why we say it stinks—the thoughts make the child feel bad, when there might be another more helpful way of looking at the situation.

This week, the children will start to identify and challenge their own *'stinking thinking'*. They are taught the following:

When we see 'stinking thinking' we can ask ourselves questions like:

- *Is there another way to look at this situation?*
- *Is that thought accurate?*
- *Is that thought helpful?*
- *(With older children) What would I say to my best friend if they were in this situation?*

When you feel yourself getting upset in a situation, stop and ask yourself these questions, because there might be a better, more realistic and more helpful way of thinking about the situation. Changing the way we think doesn't happen overnight, it takes effort to stop yourself when you notice yourself feeling upset, and question your 'stinking thinking' like we just did together. You can try doing this for all sorts of situations when you notice yourself getting upset.

Parents need to pay particular attention to thoughts around the child being responsible for the conflict and that they should be able to control it, as these are common themes among kids exposed to parental conflict/violence. When you notice stinking thinking you can say to your child, e.g. *"I see some 'stinking thinking' here. It makes you feel bad. What might be another way of thinking about this?"*

Activity for home (*GIVE PARENT THE HANDOUT, –Parent Session Summary*)

- 1) Sit down with the child and allow them to explain to you what they did in their session this week, at the designated time
- 2) Assist the child with their homework at the designated time
- 3) Keep practising the Positive Parenting skills (*USING WEEK 6 WORKSHEET 1 –Positive Parenting*).
- 4) Continue to support your child following the exposure as per last week.
- 5) Continue to work on improving the quality of your relationship with your child *–Improving Parent-Child Relationship*” – e.g. one on one time, family fun time etc....).
- 6) Put into Discipline Plan into action

Support from each of the group members.

Each group is different and some groups will like to keep in touch with each other.

Sensitively gauge if this is the case with this group. If appropriate, write up on the board peoples' names and mobile and/or email addresses.

Appendix D: Parent Notes to Accompany Child Anger Management Module.

Swinburne University of Technology

Brain Sciences Institute.

SEPARATED FAMILIES PROGRAM.

MODULE

Treating Anger Problems in Children Exposed to Conflictual Parental Separation.

Resource for PARENT GROUP THERAPISTS.

**Fallon Cook
Grant J. Devilly
Susie Sweeper**

AIMS.

The aims of the anger management component of the program are to help the children to:

- Identify how anger *looks* in both themselves and others
- Recognise their own physiological sensations and cognitive *feelings* of anger
- Learn skills and strategies to reduce immediate anger
- Learn to challenge thoughts surrounding anger- incorporating stinking thinking

PROCEDURE.

The children will be covering anger management content in their weekly group sessions, during weeks 4, 5 and 6 of the program. It is important that the parents are aware of the strategies their children are being taught so that parents can provide positive feedback to their children and help them with the strategies.

Week 4 parents group (first anger management session for kids).

Explain to the parents that we have decided to introduce an anger management component to the kids groups. Most parents raised concerns about anger in their kids so it shouldn't come as a surprise. Explain that the kids will spend some time each week on anger management over the next 3 weeks of the program.

Anger identification and expression.

The aim of this week's kid's group session is for the children to:

- Understand what anger looks like in both themselves and others
- Be able to identify how they feel emotionally and physically when they start to feel angry- so that they can identify the signs that they are getting angry,

The children will discuss how they physically feel when they start to get angry

- Shaking
- Tight muscles
- Sweating
- Heart beating fast
- Breathing fast
- Nausea

The children will also discuss how thinking becomes irrational when we get angry- we often get stinking thinking too:

- She **hates** me"
- He will **never** listen to me"
- Nobody** likes me"

The children will discuss how these thoughts are almost always wrong and just make us feel even worse.

HOMEWORK.

During the next week the kids will fill out 2 examples on the following sheet when they feel angry about something. They will tick off the physical feelings they have and write in any stinking thinking examples. Please send this back in with them next week so we can discuss their examples.

My Angry Feelings.

Date	What was I angry about?	Did I have:		Did I feel good or bad inside?	Did I have stinking thinking?
		Shaking?	<input type="checkbox"/>		
		Tight muscles?	<input type="checkbox"/>		
		Sweating?	<input type="checkbox"/>		
		Fast Heart Beat?	<input type="checkbox"/>		
		Fast breathing?	<input type="checkbox"/>		
		Sick tummy?	<input type="checkbox"/>		

Date	What was I angry about?	Did I have:		Did I feel good or bad inside?	Did I have stinking thinking?
		Shaking?	<input type="checkbox"/>		
		Tight muscles?	<input type="checkbox"/>		
		Sweating?	<input type="checkbox"/>		
		Fast Heart Beat?	<input type="checkbox"/>		
		Fast breathing?	<input type="checkbox"/>		
		Sick tummy?	<input type="checkbox"/>		

Week 5 parents group (Second anger management session for kids).

Reducing immediate anger

The aim of this week's group anger management session is for the children is to:

- Learn to implement strategies to reduce anger such as calm breathing, relaxation training and distancing themselves from the situation.
- Discuss how to challenge the –stinking thinking” surrounding their anger.

The children will discuss how it can be difficult to calm down once we are already angry, and that it is easier to stop ourselves from getting angry in the first place.

Calm breathing will be reviewed and so will *“tense and relax”*:

–Roll into a ball and tighten all your muscles, count to three and then relax. Repeat several times.”

The children will discuss strategies on how to avoid getting angry, such as removing themselves from the situation (when possible), and distracting themselves with another task-

- Read a book
- Play with toys
- Play a video game
- Go into another room or the backyard.

The kids will discuss their homework and examples of stinking thinking.

Did the stinking thinking make them feel good or bad? Was the stinking thinking accurate? Was it helpful? What might be a better way of thinking about the situation?

HOMEWORK:

- The parents should be aware that this week the children have been asked to try out some of their new strategies for dealing with anger. If the child feels like they might be getting angry they will (hopefully) be practicing their relaxation skills and will either distract themselves or remove themselves from the situation (when possible). Parents need to support and encourage this- they should discuss this with the kids during the usual time they spend discussing the therapy session.
- Parents need to be on the lookout for good behaviour. Provide positive feedback when the kids are being calm in a situation they may normally get frustrated or angry in. Let them know when you are impressed with their calm behaviour and offer a reward such as gold stars or a treat.

Week 6 parents group (Third anger management session for kids).

Challenging thoughts and implementing more effective behaviours.

The aim of this week's group anger management session is for the children is to:

- Discuss any angry episodes they have had in the past week and discuss whether the strategies helped.
- Discuss examples of stinking thinking and better ways to think.
- Understand why getting angry never helps improve the situation.

The children will discuss any angry episodes they have had in the past week and will discuss whether the strategies helped.

They will discuss the following scenario:

–Sarah is waiting in line at the canteen to buy her lunch. Katie pushes in line ahead of Sarah. Sarah starts to feel really mad because she is hungry and wants to eat her lunch straight away, so she starts to yell at Katie and tells her to go to the back of the line. Katie then starts to yell back at Sarah, and a fight starts. Katie and Sarah are both really mad and neither one of them is really listening to the other one. A teacher comes along to stop their arguing and both girls get sent to the quiet chair for some time out and have to wait an extra 5 minutes to get their lunches. Both are very unhappy and still feel quite mad at each other.”

–If Sarah had taken a deep breath and then spoken in a calm voice to Katie, what might have been different in this scenario?” (Katie might not have yelled back, teacher might not have punished them, they would have gotten their lunch sooner etc)

Did getting angry help Sarah? Did getting angry make the situation better or worse?

The children will discuss how people don't really listen to what you are saying when you are yelling- they tend to just yell back and everyone gets angry and frustrated.

It is important that parents set a good example: if the kids hear mum or dad raising their voices whenever they are angry, the kids will copy. Encourage parents to practice keeping a calm voice at all times. Even if someone is yelling at you, if you lower your voice then the other person will start to lower their voice too.

Stay calm and if the other person is angry or just isn't listening to you then it is best to walk away and do something else. It is better to wait and discuss the problem when everyone has calmed down a bit.

Appendix E: Eligibility Screening Instrument.

Family code: _____
 Parent's name: _____
 Phone: _____
 Date: _____

Screening Instrument

All grey boxes must be ticked for family to be eligible

“Thanks for calling in regards to our treatment study. I will need to ask you several questions which you may find personal in nature. Please remember that any information you tell me remains entirely confidential. If you do not feel comfortable answering a question please let me know.”

1*	Are you formally separated from your ex-partner? Have access/custody arrangements been finalised?	Yes	No
2*	Therapy sessions will be run on Tuesdays. Are you the legal carer of your child on this day? –Do they live with you on this day? If no then fill out end section*	Yes	No
3*	Has your relationship with your ex-partner been conflictual?	Yes	No
4	Is there any physical violence currently between you and your ex partner? MUST BE NO	Yes	No
5	Is there currently any violence being perpetrated against the child? MUST BE NO	Yes	No
6*	Is your child/children aged between 5 ½ to 11 ½ years?	Yes	No
7*	As described in the information sheet, treatment will take the form of either reading information about separation and parental conflict & how to help children cope OR families will attend a 7-week treatment program based at Swinburne University in Hawthorn. Families will also be required to fill out a collection of questionnaires at intake, immediately after treatment (about 8 weeks after intake for the Bibliotherapy group) and 3 months following the post-treatment assessment. Can you ensure that you and your child/children will be able to commit to these requirements?	Yes	No
8	Do either you or your child/children suffer from a disability that is either intellectual or physical? MUST NOT BE PROFOUND Describe: _____ Consider: appropriateness of the materials and their mode of delivery, access to sessions at Swinburne.	Yes	No
9*	Can you read English at a competent level?	Yes	No

Child One

Name: _____ **Age:** _____ **Code:** _____

*“Please tell me whether or not your child has reported- or you have noticed in your child- any of the following behaviours occurring **at least twice** in the past week only.” Must be „yes“ for at least one and has to be clear that behaviour is related to the conflict.*

<i>Has your child:</i>	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Had upsetting thoughts or memories about the conflict.		
2. Had upsetting dreams about the event? (or noticed other symbolic type behaviour or play?)		
3. Been acting or feeling as though the events were happening again?		
4. Been feeling upset by reminders of the event?		
5. Had bodily reactions- such as fast heartbeat, stomach churning, sweatiness or dizziness when reminded of the event?		
6. Had difficulty falling or staying asleep, over and above the normal rate expected of a 6 to 9 year old?		
7. Been irritable or had outbursts of anger, over and above the normal rate expected of a 6 to 9 year old?		
8. Had difficulty concentrating, over and above the normal rate expected of a 6 to 9 year old??		
9. Appeared to have a heightened awareness of potential dangers to both themselves and others?		
10. Been jumpy or easily startled at something unexpected?		

Child Two

Name: _____ **Age:** _____ **Code:** _____

*“Please tell me whether or not your child has reported- or you have noticed in your child- any of the following behaviours occurring **at least twice** in the past week only.” Must be „yes“ for at least one and has to be clear that behaviour is related to the conflict.*

<i>Has your child:</i>	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Had upsetting thoughts or memories about the conflict.		
2. Had upsetting dreams about the event? (or noticed other symbolic type behaviour or play?)		
3. Been acting or feeling as though the events were happening again?		
4. Been feeling upset by reminders of the event?		
5. Had bodily reactions- such as fast heartbeat, stomach churning, sweatiness or dizziness when reminded of the event?		
6. Had difficulty falling or staying asleep, over and above the normal rate expected of a 6 to 9 year old?		
7. Been irritable or had outbursts of anger, over and above the normal rate expected of a 6 to 9 year old?		
8. Had difficulty concentrating, over and above the normal rate expected of a 6 to 9 year old??		
9. Appeared to have a heightened awareness of potential dangers to both themselves and others?		
10. Been jumpy or easily startled at something unexpected?		

“Is there any other unusual behaviour you have observed in your child since they witnessed the conflict?”

“Has your child been exceptionally withdrawn?”

***If you do not have legal responsibility for your child on the day we will be running therapy. Please provide us with the contact details of the other parent of your child so that we can ask for consent for your child to participate.**

Name:

Address:

Phone:

- **Is the family eligible? Check that all relevant boxes are ticked. Offer to post out referral advice sheets if necessary.**
- **If eligible inform the family that we are happy to have them in the program and that the next step will be to come in for the intake assessment which Fallon will be running after 20th January. Tell them I will be in contact soon to arrange a convenient time.**

Also inform them that they will find out whether they will receive the therapy or the book when they have the intake and assure them that the book is very helpful and comes highly recommended.

Additional notes:

Appendix F: Parent Demographic and Wellness Assessment.

Demographic & Wellness Assessment

Name:
Relationship to child (e.g. mother, father, guardian):
Address:
Phone no.: _____ (H) _____ (W) _____ (M) _____
Date of Assessment:

1. Date of Birth: _____

2. Gender:

- 1. Male
- 2. Female

3. Ethnic Origin:

Please mark in ONE square to indicate in which of the following categories you feel you belong. (Note: this question relates to status as opposed to geographical location)

1	White/Caucasian/Northern European	
2	Aboriginal or Torres Strait Islander	
3	Hispanic	
4	Middle Eastern	
5	African	
6	Mediterranean	
7	Asian	
8	African American	
9	Polynesian	
10	Other (please identify:)	

4. Where do you live? House, flat, nursing home, caravan etc

- 1. **House**
- 2. **Flat/unit**
- 3. **Nursing home**
- 4. **Caravan**
- 5. **Other, specify** _____

5. Who are you living with? (please circle who you are living with now)

Alone	Friend/Flatmate	Family Member	New Partner	Children	Children & New Partner	Other _____
-------	-----------------	---------------	-------------	----------	------------------------	----------------

6. Are you predominantly left or right handed? (please circle)

Left Right Ambidextrous

7. What is your highest educational achievement? (What was the last grade you completed in school?)

1. Ph.D., M.D or equivalent
2. Completed tertiary education;
Specify course _____
3. Started University
Specify, what completed _____
4. TAFE course
5. Completed year 12 or equivalent
6. Some High School.
Final year complete _____
7. Completed Primary School
8. Other, specify: _____

Employment History

8. a) Usual Occupation/What is your job? _____

b) How would you classify this job?:

1. Professional

(i.e. physician, lawyer, psychologist, social worker, nurse, accountant, architect, engineer, teacher, pharmacist)

2. White-collar

(i.e. clerk, secretary, salesperson, bookkeeper, middle manager)

3. Blue-collar

(i.e. technician, labourer, mechanic, food service worker, childcare worker)

- 4. **Student**
- 5. **Homemaker(and/or full-time child caretaker)**
- 6. **Unemployed and without previous occupation**

9. a) At present, how often are you working (excluding childcare) ? _____(Hours per week)

b) How would you classify your job? (Tick the appropriate box)

- 1. **Homemaker**
- 2. **Full-time**
- 3. **Part-time**
- 4. **Casual**
- 5. **Receiving disability pension**
- 6. **Unemployed**

10. Excluding paid work, how many hours do you spend child caring during the day?
_____hours

11. What is your personal or household (whichever is relevant to you) gross annual income before tax?

- | | | | |
|------------------------|--------------------------|--------------------------|--------------------------|
| 1. Less than \$10,999 | <input type="checkbox"/> | 2. \$11,000 - \$25,999 | <input type="checkbox"/> |
| 3. \$26,000 - \$40,999 | <input type="checkbox"/> | 4. \$41,000 - \$55,999 | <input type="checkbox"/> |
| 5. \$56,000 - \$70,999 | <input type="checkbox"/> | 6. In excess of \$70,999 | <input type="checkbox"/> |

12. How many persons are dependent on this income? (Indicate number)_____

Psychiatric History

13. a. Which health services have you accessed *over the past 6 months* (and not including this study)?

Provider Type	Have you visited? (√)	Approx. n^o of times seen over past 3 months	For what reason (only mention area of concern, not specifics)?	Are you currently seeing? (√)
1. Psychologist				
2. Psychiatrist				
3. Social worker				
5. Occupational therapist				
6. Physiotherapist				
7. Day hospital				
8. Support group				
9. Counsellor (specify type)_____				
10. GP				
11. Other (please specify)				

13b. Have you ever seen anybody for professional help regarding emotional problems at any point during your life? **Yes** **No**

14. During the past 6 months you may have taken medication (prescribed or not, eg. panadol, temazepam, prozac, marijuana, etc.) and it would be very beneficial for the research to know about these so that we can see how things change over time and due to treatment. Therefore, could you list any drugs that you have taken and if possible the frequency and amount (in grammes or milligrammes).

Drug name	Duration (approx. no. of days drug taken)	Amount of drug per tablet (g or mg)	Number of tablets/amount taken per day	Are you still taking the drug (√)

Family Demographics

1. Current Marital Status:

- 1. SINGLE
- 2. MARRIED ___ YRS
- 3. WIDOWED ___ YRS
- 4. DIVORCED ___ YRS
- 5. SEPARATED ___ YRS
- 6. DE FACTO ___ YRS

2. How many previous marriages have you been in? _____

3. How many children do you have in total? _____

4. How old are your children from the relationship from which you have just separated and what is their gender?

Name	D.O.B	Where do they live most of the time (please circle)			
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other

Equal* = child spends equal time with mother and father or shared custody

5. Do you have children from a previous relationship other than from the one that You have just separated from (please list in table)?

Name	D.O.B	Where do they live most of the time (please circle)			
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other
		Mother	Father	Equal*	Other

Equal* = child spends equal time with mother and father or shared custody

6. How long since you separated from your last partner (or the other parent for the children from Question 4)? _____

7. Before the separation what was the nature of your relationship (please circle one)?

Married De Facto (living together) Boyfriend/Girlfriend
 (never lived together)

8. How long were you living together? (please include time living together before marriage if applicable) _____

9. Are you now legally divorced: (please circle one)

Yes (if so, how long?)	No	Not Applicable

10. How long have you been living apart from your former partner? _____

11. How often in the past month have you had face to face contact with the other parent of your children? (please circle one)

Never once or twice weekly more than weekly

12. How often in the past month have you had phone contact with the other parent of your children? (please circle one)

Never once or twice weekly more than weekly

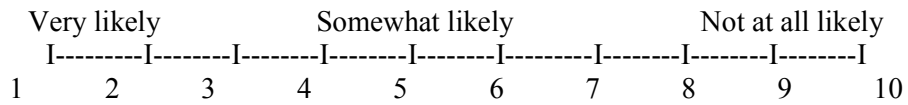
13. Are there parenting orders (i.e., a legally binding document) in place? (please circle one)

Yes No

14. If yes, how many times have they been breached in the last 2 months? (please circle one)

Never Once Two Three or more

15. On a scale of 1 to 10 how likely do you believe it is that you will go to court over parenting arrangements in the next 6 months (please circle one number on the line below).



16. What are the current living arrangements for your children?

General: (e.g., Mon – stays with me, Tues – spends the day and night with father etc)

Mon Tue Wed Thu Fri Sat Sun

Mon Tue Wed Thu Fri Sat Sun

Additional times:

(e.g. Public Holidays – spends first half of holidays with me, the other half with mother)

Public holidays

Easter

Christmas

Birthdays

Annual Leave

Mother’s and Father’s Day

17. Whose decision was it to separate?: (please circle one)

You Partner Mutual Decision

18. Did you want the separation (please circle one)?: Yes No

19. a) Prior to the separation have you sought counselling or psychological help professionally (please circle one)?

Yes No

b) Did the help consist of (please circle all those which are relevant):

Individual Counselling	Relationship Counselling	Hospitalisation	Psychiatrist	Religious	Other (please describe):
------------------------	--------------------------	-----------------	--------------	-----------	--------------------------

20. Did you attend mediation with your partner during the process of separation? (please circle one)

Yes (go to Qu.21) No (go to Qu.27)

21. If yes, was mediation completed? (please circle one) Yes No

22. How many days did you attend mediation? _____ days

23. When did you attend mediation (indicate month/s and year)? _____

24. Did you end up attending court for the issues discussed in mediation? (please circle one)

Yes No

25. Where did you attend mediation (which organisation)? _____

26. How helpful did you find mediation (please circle one)?

Very Unhelpful	Unhelpful	Neither Helpful nor Unhelpful	Helpful	Very Helpful
----------------	-----------	-------------------------------	---------	--------------

27. Is there any legal action currently taking place between you and your former partner (please circle)?

- Divorce proceedings
- Property settlement
- Child maintenance costs
- Child custody
- Domestic violence or restraining orders
- Other: _____

28. a) Are your parents divorced (please circle one)? Yes No

b) If yes how old were you when they divorced? _____

29. Do you have more or less money to spend on yourself now (please circle one)?

A lot more	Somewhat more	About the same	Somewhat less	A lot less
------------	---------------	----------------	---------------	------------

30. a) Are you currently seeing or dating other people or in a committed relationship? (please circle one)

Yes

No

b) If yes, (please circle one)

One date	Several dates	Date regularly over a long period of time	In a committed relationship
----------	---------------	---	-----------------------------

31. How much time on average do you spend with your children (who are under 18 years of age)?

- a. less than one day per week
- b. 1 to 2 days per week
- c. 3 to 4 days per week
- d. 5 to 7 days per week

Other: _____

32. a) Is this arrangement acceptable to you? (please circle one) Yes No

b) If not, why not?

33. If you do not live with your children, what distance is there between you (approximate kms) _____?

34. a) Do you pay child support to your former partner for your child/children (please circle one)?

Yes

No

b) How much child support do you pay (per week)?

c) Do you believe that this is an equitable amount? Yes No

35.a) Do you receive child support from your former partner for your child /children (please circle one)?

Yes

No

b) How much child support do you receive (per week)?

c) Do you believe that this is an equitable amount? Yes No

Appendix G: PFI Form 3.

Kindly reprinted with permission from the author, Beth Stone.

PFI Form 3

How Much or How Often Do You Feel [Each PF]?

Name/no. _____ Interviewer _____

Date _____ Place _____

Instructions

The interviewer says:

A We are interested in people's feelings, and we want to know what *you* feel. *How much or how often* have you felt each Pictured Feeling? Tick or circle how much you feel each: 1, 2, 3 or 4 under A below.








B Since we don't always *show* what we feel, we'd like to know what feelings you show in front of other people. Tick ✓ column B if yes, you show the feeling in front of others.

C Is the feeling a *problem* for you? Then just ✓ tick for yes.












NOTE: Look at each Pictured Feelings Instrument card, remembering that the arrow points to the person who has the Pictured Feeling.

NOTE:









- Use full-size PFI cards to answer.

PF	A. To what extent – how much or how often – have you felt this? Just ✓ tick or circle the number				B. I showed the feeling		C. The feeling was a problem	
	Hardly ever/ Very little	Sometimes/ Moderately	Often/ Quite a lot	Most of the time/A great deal	B ✓ tick if yes		C ✓ tick if yes	
 1	1	2	3	4	1		1	
 2	1	2	3	4	2		2	
 3	1	2	3	4	3		3	
 4	1	2	3	4	4		4	
 5	1	2	3	4	5		5	
 6	1	2	3	4	6		6	
 7	1	2	3	4	7		7	

PFI Form 3 How Much or How Often Do You Feel [Each PF]?

PF		A. To what extent – how much or how often – have you felt this? Just ✓ tick or circle the number				B. I showed the feeling		C. The feeling was a problem	
		Hardly ever/ Very little	Sometimes/ Moderately	Often/ Quite a lot	Most of the time/A great deal	B ✓ tick if yes		C ✓ tick if yes	
	8	1	2	3	4	8		8	
	9	1	2	3	4	9		9	
	10	1	2	3	4	10		10	
	11	1	2	3	4	11		11	
	12	1	2	3	4	12		12	
	13	1	2	3	4	13		13	
	14	1	2	3	4	14		14	
	15	1	2	3	4	15		15	
	16	1	2	3	4	16		16	
	17	1	2	3	4	17		17	
	18	1	2	3	4	18		18	

PFI Form 3 How Much or How Often Do You Feel [Each PF]?

PF		A. To what extent – how much or how often – have you felt this? Just ✓ tick or circle the number				B. I <i>showed</i> the feeling		C. The feeling was a <i>problem</i>	
		Hardly ever/ Very little	Sometimes/ Moderately	Often/ Quite a lot	Most of the time/A great deal	B ✓ tick if yes		C ✓ tick if yes	
	19	1	2	3	4	19		19	
	20	1	2	3	4	20		20	
	21	1	2	3	4	21		21	
	22	1	2	3	4	22		22	
	23	1	2	3	4	23		23	
	24	1	2	3	4	24		24	
	25	1	2	3	4	25		25	
	26	1	2	3	4	26		26	

Appendix H: Ethics Clearance.

This research project was carried out with Swinburne University Human Research Ethics Committee approval (SUHREC project 05/38). However, when the Chief Investigator moved the project to another University (Griffith University, Queensland), all raw identifiable data and prior SUHREC correspondence (including ethics approval letters) moved also. I no longer have access to these documents and therefore cannot provide evidence of the ethics approval, other than citing the SUHREC project number- 05/38.

Renewed ethics approval was granted in 2008 (SUHREC project 2008/135), to allow the author to continue using the de-identified data for the completion of this thesis, in the absence of the Chief Investigator. An email stating approval is inserted in the following two pages.

I hereby state that all conditions pertaining to the clearance were properly met, and that annual/final reports have been submitted.

Signed by the author _____ Date: _____

To:

Dr Joseph Ciorciari/Ms Fallon Cook, BSI, FLSS
c Prof Michael Kyrios, FLSS

Dear Joe and Fallon

SUHREC Project 2008/135 Assisting children affected by parental separation and exposure to parental conflict" - a request to use de-identified data from completed SUHREC Project 05/38
Dr Joseph Ciorciari FLSS Ms Fallon Cook
Approved Duration: 12/12/2008 To 31/12/2009

Ethical review of the above project protocol was undertaken by Swinburne's Human Research Ethics Committee (SUHREC) at its Meeting 8/2008 held 12 December 2008, the outcome of which as follows.

Whilst noting that the student interest should have been accounted for at the earliest practical opportunity within SUHREC Project 05/38, the Committee agreed that there was sufficient justification to approve the request to use de-identified data as submitted. Standard on-going ethics clearance conditions (as applicable) are listed below.

In arriving at its decision, the Committee received a report on the background to the project. Also, as part of its decision, the following pertained:

- The Committee accepted that it was problematic to go back to individuals for consent to extract data in de-identified form given the circumstances pertaining to a vulnerable group of individuals.
- The PhD interest was sufficiently in accord with the larger project and it was likely that individuals would have agreed to it had the matter been put to them within Project 05/38 consent procedures.
- Furthermore, given that Project 05/38 was being transferred to Griffith University and their HREC had given ethics clearance, it was noted that Assoc Prof Grant Devilly (now at Griffith University) was to apprise participants of the project and data transfer and of their continuing rights and interest as per existing informed consent arrangements including their right to withdraw participation in the project. Sufficient information about the PhD interest was also to be included in the same letter. Apprising individuals of the changed circumstances formed part of conditions set by Swinburne for transferring Project 05/38, such conditions being consistent with advice received with respect to Health Privacy Principles scheduled under the Victorian Health Records Act.

The Swinburne Standard Conditions for On-Going Ethics Clearance are as follows:

- All human research activity undertaken under Swinburne auspices must conform to Swinburne and external regulatory standards, including the National Statement on Ethical Conduct in Human Research and with respect to secure data use, retention and disposal.
- The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel

appointed to or associated with the project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and SUHREC endorsement.

- The above project has been approved as submitted for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require prior ethical appraisal/ clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects on participants and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.

- At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.

- A duly authorised external or internal audit of the project may be undertaken at any time.

Please contact me if you have any queries about on-going ethics clearance. The new SUHREC project number should be quoted in communication.

Best wishes for the project.

Yours sincerely

Keith Wilkins
Secretary, SUHREC

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