

Running head: GROUP THERAPY AND CHILDREN IN FOSTER CARE

Using Group Therapy to Improve the Well-Being of Children in Foster Care

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Abstract

There is little research on the effectiveness of group psychotherapy for children in foster care (Craven & Lee, 2006; Mellor & Storer, 1995; Williams, Fanolis, & Schamess, 2001). Youth in foster care are an at-risk population who generally are more vulnerable to various psychological issues including neglect and abandonment as well being predisposed to mental health problems from first generation biological parents (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Garwood & Close, 2001). This study evaluates the effect of attachment theory on children as it relates to psychopathology and behavior. According to Howe (2006) abused and neglected children with dysfunctional attachment relationships suffer more complex and profound impairments as they experience the worst facets of both avoidant and ambivalent custodial environments. In addition, this writer will review the history of the various social service organizations that impact children who enter the child welfare system. The primary objective of this study is to measure the effectiveness of group psychotherapy as a therapeutic intervention for children in foster care (CFC). Children in foster care are often a population whose therapeutic goals and objectives tend to focus on psychopathology and behavior management but little attention is paid to the culture and experiential component of what its like to be a child in foster care. A child from nowhere and whose identity, culture and caregiver may shift with each new environmental transition or experience.

Using Group Therapy to Improve the Well-Being of Children in Foster Care

There is a shortage of research measuring the effectiveness of practical interventions such as group counseling with children in foster care (Craven & Lee, 2006; Mellor & Storer, 1995; Williams, Fanolis, & Schames, 2001). For a government agency to determine that a child needs to be removed from their home requires evidence that the home is an unhealthy environment for that child. Typically, this means that the child has been the victim of abuse or neglect by the primary caregiver. At the same time, being displaced or taken from their home is often a traumatic experience for children. To be taken from the only caregiver known to you, even if that person mistreats you, is often a daunting and stressful circumstance for children. Children from low income and minority families are overrepresented in the foster care system and they face additional financial and societal challenges (Craven, 2008). As a result of these early experiences, children in foster care frequently develop problems related to attachment, trauma, anxiety and depression. These psychological problems often lead to emotional dysregulation that manifests in a wide range of problematic behaviors (Feeney & Noller, 1996). These problematic behaviors often trigger the initiation of treatment either through outpatient care, inpatient hospitalization or school related interventions. There is a shortcoming of research measuring the effectiveness of practical interventions, such as group counseling, with children in foster care. Given the high-risk profile of these foster care children; it's imperative that researchers identify effective treatments for use with this population.

The aim of this study is to see if group interventions are a useful component in the mental health care of foster children. Many times, the mental health treatment of CFC are based upon their gender, diagnosis or presenting problematic behaviors such as physical aggression or sexual acting out (National Commission on Family Foster Care, 1991). While these factors are

unquestionably important to consider in the treatment of CFC, treatment must also consider the unique background and experiences related to being in the foster care system. The nature of this study is to provide a theory of intervention that considers the shared experiences of these children based on their experience in the foster care system. By providing an intervention for this classification of children based upon common experience, this writer hopes to enhance the delivery of care for CFC.

This author will utilize terms interchangeably throughout this document in regards to explaining interventions and the population of subjects within this study. The terms group therapy, group counseling and group psychotherapy will be used interchangeably to describe any form of therapy or psychotherapy delivered in the capacity of forming relationships using a systemic format delivery system within a group of participants (Donigian & Malnati, 1997; Yalom & Leszcz, 2005). In addition, the author will use the term children in foster care (CFC) to describe both children and adolescents under the age of eighteen and having been or currently residing within the foster care system.

The significance of this study is to introduce a proven method of therapy and apply it to working with a select group of children. By implementing preventive modalities of treatment such as group counseling, it is this writer's opinion that the therapeutic criteria of group counseling will provide a cohesive bond and assist in providing children with the psychoeducational tools and emotional awareness needed to thrive in less than perfect environments. Group therapy can forge emotional connectedness, relieve anxiety and provide another modality to assist in the well-being of CFC. It is this writer's hope that through the use of group therapy these forgotten children will gain the tools necessary to become functioning

members of society and not trans-generational reflections of their biological parents or manifestations of their faulty often chaotic living situations (Palmer, 1990).

Review of the Literature

Foster Care System

One of the main goals within the foster care and child welfare systems is permanency planning; finding a permanent suitable custodial environment for kids whose custody status is disrupted primarily due to abuse and neglect (Evans, 1997). Typically, those who care for the youth, which include representatives of the legal system, child welfare agencies, and at times foster and biological parents, have the legal and psychosocial goal of providing the child with stability and placement (Schweitzer & Larsen, 2005). Planning for and caring for CFC is difficult because of a myriad of factors that may disrupt or discontinue a foster care placement. These factors include problematic behaviors, mental and physical health concerns as well as legal and custody status. As a result many children in the foster care system are frequently moved around and placed in multiple settings causing disruption (Newton, Litrownik, & Landsverk, 2000).

Foster care dilemmas

The scope of problems within the child welfare system is daunting in nature. Frequent scandals, overloaded child-welfare worker's and governmental policy often make kids in care victims of neglectful systems instead of cared for children (Schwartz & Fishman, 1999). How best to improve this system seems a question similar to the quandary of "what is the cure for the common cold?" It is at best a pervasive problem with an evolutionary answer and historical mistakes that hinder progress and effective program development (Evans, 1997). Furthermore, the division of practice between various states and associated municipalities further hinders the

uniformed intervention for providing the best care for CFC (Clausen et al., 1998; Schweitzer & Larsen, 2005).

Socio-economic setbacks of the foster care and child-welfare system

With over 500,000 children in foster care, economic needs are at the forefront of where children who become wards of the state are placed (Administration for Children and Families; U.S. Department of Health and Human Services, 2008; Evans, 1997). The high numbers of CFC combined with multiple placement disruptions cause for foster care youth to develop problems of conduct-like behavior, mental and physical health concerns as well as the economic cost to tax payers. The frequent disruption in living situations causes fragmented services and disturbances between health care providers and school systems (Newton et al., 2000). Youth with serious and persistent health care and socio-emotional dilemmas are often subjected to bottom of the barrel care because many health care practitioners refuse to service medicaid clients (Evans, 1997). Since most foster care children are under the Medicaid/Medicare system it is likely that many will fall into this quandry of insufficient care with little or no right to selection of services.

Developmental and Mental Health Concerns of CFC

Studies indicate that children in foster care have a high degree of risk for developmental and mental health problems as well as numerous risk-factors associated with the child-welfare system (Chernoff, Combs-Orme, Risley-Cutiss, & Heisler, 1994; Clausen et al., 1998; Garwood & Close, 2001; Newton et al., 2000; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). Newton et al. (2000) performed a longitudinal study of children in foster care over a 12-month period that was designed to look at the relationship of problem behaviors and placement disruption between a cohort of foster children. The results of the study suggested that the erratic and sudden change of foster care placements contributes negatively to the internalizing and

externalizing of foster children's behavior. The study concluded that the epidemiology of negative behaviors as a result of placement disruption and the change associated with strained relational ties to caregiver family's result in the negative consequences of psychopathology and socio-emotional wellness (Newton et al., 2000).

Childhood Attachment

According to a 2006 report of CFC in the United States; the largest age of children displaced and put into foster care are less than one-year old. Furthermore, almost a third of children who enter foster care are three years old and under. (Administration for Children and Families; U.S. Department of Health and Human Services, 2008). Important attachment relationships and developmental progression take place during the first year which tends to correlate to disruptive relationships and dysfunctions in personality development (Bowlby, 1988).

Attachment theory

Attachment theory relates to the most innate understanding of developmental psychology and human development. At the very core, this theory explains how our early development and environmental experiences correlates to how we understand the world and interact within it (Bowlby, 1988). Bowlby (1988) stated that early attachment experiences have long lasting effects that tend to persist across the lifespan and are among the major determinates of personality organization and psychological disturbance. It is doubtful to assume that we are autonomous beings who can stand alone because at the very core of our genetic make-up lies the requirements of comfort and security in others in order to maintain a level of homeostasis (Bowlby, 1988). John Locke's theory of human nature referred to the Latin phrase "tabula rasa" to explain nature vs. nurture (Locke, 1959). Locke's theory stated that we are all born with blank slates and throughout our development we add to this slate based upon our environment and

surroundings (Locke, 1959). Bowlby's (1988) views on human behavior state that the human species is equipped with numerous behavioral schemas which continue to evolve as our environment changes but are the integral often innate characteristics which are relevant to species survival. Attachment theory and in particular the theory of attachment disruption is therefore a response to the environment that we are exposed too and how we as humans grow and develop as a result of our biological make-up interacting with the world around us.

Attachment behavior

Bowlby (1988) argued that there is plenty of empirical evidence to support the etiological idea that when a infant or child is scared, that child will gravitate to a certain person(s), and if that certain person(s) is not present, the child will instinctually find someone who exhibits the characteristics of what that child needs in the moment (i.e. comfort and security) (Bowlby, 1988). When suffering stress, fear and anxiety, children show a clear hierarchy of preference (Bowlby, 1988). That is why when a child is lost in a supermarket most will gravitate to a stranger who is often a nurturing mother figure who is assertive in trying to assist the child (Ainsworth, Blehar, Waters, & Wall, 1978). Often times, if the child does not discern or implement this hierarchal system of attachment figures it is indicative of an attachment disturbance and is a pathological thematic-symptom, which may highlight a predisposition to future behaviors and psychological distress (Bowlby, 1988).

According to Bowlby (1988) attachment behavior is any form of behavior that is done consequently to attain or maintain a sense of propinquity to another individual(s) who is thought to be better suited to cope with the environmental surroundings (i.e. mother, father, older sister, foster parent). This behavior becomes most prevalent in times of crisis when the infant child or adult becomes anxious, frightened or sick (Bowlby, 1988). Attachment behavior is most obvious

as an infant or child but extends over the life span. It is a trait or characteristic that is seen virtually in all human beings and is one that is shared to a varying degree with all members of the animal species (Bowlby, 1988).

Ainsworth et al. (1978) wrote a book about the strange-situation assessment environment for toddlers and young children to measure and observe behavioral illustrations within a structured environment. An example of attachment behavior in Ainsworth et. al. (1978) includes the following:

Sometimes a behavior, not activated intensely enough to override another behavioral system that blocks its expression, may be redirected toward a goal object other than toward the one that elicited it. Thus a person whose aggressive/angry behavior is activated by the actions of another whom he is also afraid or fears to offend may “redirect” aggressive behavior toward a third person or toward an inanimate object – an outcome referred to by psychoanalysts as “displacement.” (p. 15)

It is evident throughout the literature that this set of researchers value the interaction between the mother-child and the effects of transition affect on attachment relationships and subsequent attachment behavior as it relates to functional versus dysfunctional behavior (Ainsworth et. al., 1978).

Attachment research

According to Howe (2006) attachment systems refer to the protection of ones self at times of danger. Attachment in infants is most prevalent based upon the dependency one has on the caregiver. Attachment behaviors are most exhibited as responses to fear, anxiety, confusion or feelings of abandonment (Howe, 2006; Solomon & George, 1999). Relationships are often the key tenets to attachment stability versus attachment disruption. So it is not surprising that when

children who have experienced abuse, neglect and trauma, as many CFC have, act out, hoping to meet their own needs, they tend to further damage healthy relationships. Children who experience acute tension, psychosocial stress and rejection from primary caregivers can suffer growth failure and poor psychological health (Howe, 2006). Children who are exposed to trauma and stress at an early age, even infancy, spend so much mental energy focused on things out of their control and exhibit anxious thoughts, feelings and behaviors that little time is spent exploring, playing and enjoying other developmentally appropriate pleasures (Bruskas, 2008; Clausen et al., 1998 Howe, 2006; Simpson & Rholes, 1998). With children in foster care, it is important to find homes and caregivers who are emotionally available and project less psychological and psychosocial stress on a young person. Adoption and foster care research repeatedly reports that quality social support, from family or community resources correlates with better placement outcomes (National Commission on Family Foster Care, 1991).

According to a longitudinal study by Waters et al. (2000) which measured the attachment development of sixty middle-class caucasian infants from twelve months to twenty years of age, it was determined that early attachment security is significantly related to attachment security twenty years later. The study utilized the Adult Attachment Interview (AAI) in conjunction with the Strange-Situation Attachment Assessment which was completed for the participants at one year of age. The measures were assessed and correlated under the classification of three character traits of attachment; secure, insecure-avoidant and insecure resistent (Waters et al., 2000). The results indicated that thirty-six out of fifty participants (72%) of the children assessed (n=50) were classified under the same attachment label in both infancy and then again in early adulthood when assessed nineteen years later. This study denoted three major points; the value of a secure base in attachment relationships in infancy and adulthood, Bowlby's concept of

individual differences and similarities of relationship concepts across the lifespan and that attachment relationships remain open to revision in light of real experiences (Waters et al., 2000).

Attachment research with children in foster care

There is a strong correlation between attachment disruption and CFC (Ainsworth et al. 1978; Bowlby, 1988). As such there is research pertaining to attachment theory and its affects on children. As CFC are a minority group and represent a small portion of the child population; there is limited empirical research between the etiology of attachment theory and children placed in the foster care system (Cappelletty, Brown, & Shumate, 2005).

Cappelletty et al. (2005) investigated an assessment instrument used to diagnose Reactive Attachment Disorder (RAD) using the *Randolph Attachment Disorder Questionnaire* (RADQ) on a sample of fifty-four children in some form of state custody, including; therapeutic foster care, adopted children, children in group homes and children placed with a biological family member(s). Historically, as reported by Cappelletty et. al. (2005) children in foster care have experienced multiple placements, most notably beginning with the separation from birth parents to placement(s) in multiple foster homes resulting from the foster parents inability to deal with the problematic behaviors of the children they choose to care for. The data collected in this study adds up to more than a 100% because many of the children were in placement for a multitude of reasons. Of the children on which data was collected (n=54), 31% entered care because of abuse, 87% for neglect, and 3% for delinquency. Over two-thirds of the individuals had less than five placements and there were some children in the study who had from five to twenty placements (Cappelletty et. al., 2005). Overall, the study concluded that children in care are more susceptible to mental health difficulties as well as attachment problems than those of normative sample,

which the study utilized to correlate against the data collected (Cappelletty et. al., 2005). In addition, the study found the RADQ to be empirically flawed because there is little no information on the validity of the measure (Cappelletty et. al., 2005).

Foster Care Prevention and Intervention

Foster care prevention

Bowlby (1988) selected to research the displacement and transition of children from their homes to systems of care for the following reasons: It is an event that could have serious mental health effects as well as an adverse effect on personality development. There could be no ambiguous interpretation of how a parent raised a child other than the fact that the child was taken out of the home, it happened and it plays some role in the make-up of the family or child's development. Lastly, it appears to be a field in which preventative measures can be implemented, in hopes of minimizing the amount of collateral damage a child or family experiences and/or how they experience it (Bowlby, 1988).

According to a report by the U.S. Department of Health and Human Services (2008) in 2006 almost half the youth in foster care throughout the country resided in foster homes with non-relatives. This type of displacement can cause an adverse effect on young children so effective interventions and preventative measures are put in place in order to give support to this population (Newton et al., 2000).

Therapeutic interventions

Craven and Lee (2006) evaluated eighteen empirically based studies that synthesized the research and intervention strategies for children in foster care. Nine interventions focused on addressing specific problems and behaviors and nine interventions focused on providing preventative measures to address at-risk children and CFC. There was limited empirical research

on specific interventions for the population of youth who reside in foster care placements. Only six interventions out of eighteen were tailored to the specific population of children in foster care. This study determined out of all the studies which were evaluated, none addressed the uniqueness of the family dynamic for CFC. The study's overall conclusion was a call for more research based upon the need for evidenced based intervention/prevention techniques for CFC who dominate most of the social service/child welfare population (Craven & Lee, 2006).

Garwood and Close (2001) researched the importance of psychological screening for children in foster care. Various developmentally appropriate screen procedures and measures were used to assess the population based primarily upon age as the study varied in ages from one to seventeen years of age. Measures assessed for cognitive, behavioral and emotional domains as categories and sub-categories for assessment. In addition, caregivers were also given assessments and questionnaires to rate the children in their custody. The results indicated that there is a definite need for a battery of testing to assess CFC because of their high-risk of pathological concerns, co-occurring disorders and dysfunction in personality development (Garwood & Close, 2001).

CFC often have concerns other than psychological problems. As a result of abusive and neglectful backgrounds, most CFC also have health related setbacks (Chernoff et al., 1994). Chernoff et al. (1994) studied the health care problems of children entering the foster care system. They evaluated the health status of children (n=1407) over a two year period. The results indicated that greater than 90% of children evaluated had at least one abnormality in at least one body system. In addition, 25% failed vision tests and 15% failed hearing tests. Furthermore, the children evaluated were also shorter and lighter than normal (Chernoff et al. 1994). The results also indicated that 75% (n=1407) had a family history of mental illness or drug/alcohol abuse. Of the children evaluated who were older than 3 years of age, 15% admitted to suicidal ideation and

7% to homicidal ideation. Furthermore, 23% of the children evaluated younger than five years of age had abnormal or suspect results on developmental screening exams (Chernoff et al. 1994).

Klee, Kronstadt, and Zlotnick (1997) assessed infant and toddler CFC (n=125) ages <12 months to 36 months. It was determined that half-rated below normal on mental and psychomotor developmental measures and two-thirds below normal on emotion-regulation and motor quality.

Group Therapy with Children

Group Counseling is often a useful tool when working with children. Group therapy works as a systemic model to help manifest situations that assist young people with avenues needed for therapeutic change. They allow for realistic and controlled situations to be brought up and handled within a small group context. In addition, this much therapeutic environment helps children grow through the notion of commonalities and developmental age similarities.

According to the Association for Specialists in Group Work (ASGW) they define group therapy as a broad professional practice, which involves giving assistance to, and the accomplishment of tasks or goals in a group setting. Furthermore, it involves the use of group theories and process orchestrated by a trained professional to help a cohort of individuals reach mutually agreed upon goals and objectives (ASGW, 1991).

Types of group work

According to the (ASGW, 1991) there are four types of group work:

Task/Work Groups. Much work in contemporary Western society is accomplished through group endeavor. The task/work group specialist is able to assist groups such as task forces, committees, planning groups, community organizations, discussion groups, study circles, learning groups, and other similar groups to correct or develop their

functioning. The focus is on the application of group dynamics principles and processes to improve practice and the accomplishment of identified work goals.

Guidance/Psychoeducation Groups. Education and prevention are critically important goals for the contemporary counselor. The guidance/psychoeducation group specialist seeks to use the group medium to educate group participants who are presently unaffected about a potential threat (such as AIDS), a developmental life event (such as a transition point), or how to cope with an immediate life crisis (such as suicide of a loved one), with the goal of preventing an array of educational psychological disturbance from occurring.

Counseling/Interpersonal Problem Solving Groups. The group worker who specializes in counseling/interpersonal problem solving seeks to help group participants to resolve the usual, yet often difficult, problems of living through interpersonal support and problem solving. An additional goal is to help participants to develop their existing interpersonal problem-solving competencies that they may be better able to handle future problems of a similar nature. Non-severe career, educational, personal, social, and developmental concerns are frequently addressed.

Psychotherapy/Personality Reconstruction Groups. The group worker who specializes in psychotherapy/personality reconstruction seeks to help individual group members to remediate their in-depth psychological problems. Because the depth and extent of the psychological disturbance is significant, the goal is to aid each individual to reconstruct major personality dimensions. (p.13)

This writer's research on group intervention will primarily focus on psychoeducational and social skills as well as counseling and interpersonal intervention techniques. By teaching coping

skills as ways to manage everyday situations as well as utilizing a counseling approach to develop group and individual self-awareness, this writer hopes to observe significant changes in group participants.

Therapeutic settings

Effective psychotherapy with children is essential in order to aid in the treatment of and reduce problematic symptoms and behaviors of kids dealing with the effects of psychopathology (Kazdin, 1993). The format of a counseling/psychoeducational group is a viable choice for the delivery of therapy services, given the amount of time children spend in groups with their peers, both in and out of a school classroom. It is feasible to deliver services such as group therapy, within the context of an environment such as school because children often spend a large portion of time in school, which makes this setting important within their social milieu (Kulic, Horne, & Dagley, 2004).

According to a meta-analytic study composed by Hoag and Burlingame (1997), groups for children primarily take place within an academic setting. This is because most children are in school throughout the day and school is the place where many children receive therapeutic services. As a result of Hoag and Burlingame's study (1997) of outcome measures of 56 child and adolescent groups from 1974 to 1997, they determined that almost 74% of these outcome studies of group counseling occurred in school settings, 8% were in inpatient settings and 6% were offered through outpatient settings. In a similar study performed by Kulic, Horne and Dagley (2004) whereby the researchers measured prevention oriented groups for children and adolescents from 1990 to 2000; they found that 79% of the studies took place in school settings with the remaining taking place in clinical settings, such as an inpatient or outpatient facility.

Having a group within a K-12 school setting is common in the United States based upon the longitudinal studies that were done from 1974-1997 and 1990 -2000 (Hoag & Burlingame, 1997; Kulic, Horne, & Dagley, 2004). Parents generally work throughout the day and to attend outpatient therapy in a community based setting is often difficult because it requires the parent or child to have to get time off from school or work. It is this factor that makes running psychotherapy groups in schools a useful and practical tool for serving greater numbers of children in a common setting.

Children's Group Variables

Change agent professionals

Since most children's groups are run in school settings, there may be a shortage of professionals trained to lead or co-lead group interventions (Kulic, Horne, & Dagley, 2004). It has been argued that all professional therapists should hold generalist knowledge of skills in group work. To be a competent group therapist this basic foundation is essential to the specialized training needed to be an effective group leader (ASGW, 1991).

Kulic et al. (2004) reviewed the studies of child and adolescent prevention groups and concluded that a large body of group work took place in school settings. Furthermore, their research noted that 39% of prevention groups are lead and co-lead by school counselors as well as community based master's level mental health professionals (the majority were school counselors). In addition, the second largest category of change agent staff that conducted group work (17%) represented teaching professionals as the primary intervention change agent (Kulic et al., 2004).

It is vital in group therapy to have change agent professionals that have training and supervision in the science and art of group therapy (Velsor, 2004). Without proper training and

supervision many variables may effect the therapeutic process. Issues such as counter-transference are common attributes plaguing many therapists who do not develop the experiential componet of their group therapy training (Yalom & Leszcz, 2005).

Gender and multicultural attributes

The formation of a group is important in creating an enviroment of growth and change (Yalom & Leszcz, 2005). Within this social context factors such as race, gender, and culture play an intrical role in replicating a realistic enviroment, much like that of a park, playground, or school. In the Kulic et al. (2004) study of prevention groups of children and adolescents, they report that a majority of the studies indicate that groups are of mixed gender. The studies which were gender specific often took place in scpecialized boarding schools or more specified groups like aggressive boys (Kulic et al., 2004).

Multicultural competence plays a significant role in assesing treatment outcomes in group therapy. Often race and multicultural factors play an intricate role in the bonding and forming of psychodynamic groups (Chen, Kakkad, & Balzano, 2008). In this writer's research cultural competence is more than just being aware of race and ethnicity, but being attentive to the culture and identity which can be formed as a result of particular experiences and settings, such as those experienced by children in foster care. Maslow (1943) demonstrated that there are physiological and psychological needs, which provide humans with a homeostatic sense of being, most notably demonstrated in *Maslow's Hieracrhy of Needs*. Maslow's hierarchy illustrates that children, such as those in foster care who are not getting their needs met and have been exposed to trauma, abuse and neglect fom an early age, are more susceptible to the symptomatic and behavioral problems associated with post-traumatic stress, develomental neglect as well as attachment disruption. It is therefore understandable and even expected that it may be hard for

some children to be attentive, participative, and acculturated to the group dynamic, while involved with group psychotherapy. Being aware of cultural factors as well as cultural experiences is a vital tool in promoting group cohesion and self-awareness.

Also affecting whether group therapy is an effective intervention is an individual's or family's socioeconomic status (SES). According to Hoag and Burlingame's (1997) meta-analytic study of child and adolescent groups, children classified as middle class were more successful and reported greater therapeutic gains than did children who were classified in a lower socioeconomic class. In Kulic et al. (2004), a study of prevention groups of children and adolescents, it was determined that twenty percent of the studies reviewed over a ten year span (1990-2000) contained little to no information about race, ethnicity or socio-economic class.

Based on this writer's review of the research, when a child's basic needs are not met, it may be hard to function in a group environment- whether it be a school setting or a group therapy room at an outpatient clinic. It is necessary to include multicultural competence in outcome studies of group psychotherapy to provide an accurate portrayal of group outcomes as it applies to the reporting and dissemination of reliable evidence-based practice (EBP).

Therapeutic factors

Therapeutic factors are a vital tool in identifying and verifying whether a therapeutic intervention such as group counseling is effective or not. Therapeutic factors verify how individuals are helped in group counseling and psychotherapy (Shechtman & Gluk, 2005). According to Yalom and Leszcz (2005), there are eleven factors which are essential elements to the group-change process; these therapeutic factors are (1) the instillation of hope (2) universality (3) altruism (4) imparting information (5) development of socializing techniques (6) family recapitulation (7) interpersonal learning (8) catharsis (9) imitative behavior (10)

cohesiveness and (11) existential factors. These factors are generally accepted by the therapeutic community and Yalom himself is cited in almost all contemporary literature pertaining to group psychotherapy from 1985 to the present.

A large variable in assessing the impact of these factors has to do with the therapeutic setting as well as the group leader(s) running the intervention (Shechtman & Gluk, 2005). A cognitive behavioral children's group may differ from a child centered-play therapy group and so different therapeutic factors may be more prevalent in each of these different subtypes of the group interventions based upon the group leader's theoretical orientation and modality of practice (Lopez & Bhat, 2007).

Group Therapy with Children in Foster Care

There is limited empirical data and research that proves the effectiveness of group therapy as an intervention for children in foster care (Craven & Lee, 2006). To date, only one quantitative study that illustrates the efficacy of group therapy with children in foster care has been published. In addition, there are several studies which look at the effectiveness of group therapy with CFC. They include one quantitative study as well as a handful of qualitative research that provides valuable intervention techniques but lack empirical data and therefore the efficacy to be considered effective evidenced based practice (EBP). Proper EBP is important due to third-party insurance and governmental agency reimbursement of services rendered (Whaley & Davis, 2007).

Group interventions with CFC

The following study developed an intervention model of group therapy for children in foster care placement. The intervention used was *Transitional Group Therapy* (TGT). The aim of the study was to provide an increase in personal resilience and provide empirical data to support

the effectiveness of TGT. Two assessments were utilized to measure for quantitative change, growth and pathology among the participants (Craven, 2008). The *Child Behavior Checklist (CBCL)* is an assessment for children ages 4-18 years and is the most commonly used measurement in published studies of child psychopathology (Tacket & Awong, 2007). The *Behavior and Emotional Rating Scale (BERS)* is a strength based assessment for children ages 5-18 years which measures emotional and behavioral skills, competencies, characteristics of relationships, ability to deal with stress and academic development (Craven, 2008). The *CBCL* results indicated a significant improvement on four out of eight subscales after a 12-session group therapy intervention. The *BERS* results indicated an improvement on three out of five subscales after a 12-session group therapy intervention (Craven, 2008).

TGT offers an evidence-based approach of service delivery to a population of children experiencing problems relating to displacement (i.e. children in foster care). In addition, this model of therapy offers a strength based intervention that focuses on promoting resiliency in children who experience frequent adjustment problems and transitional living situations (Craven, 2008).

Williams, Fanolis, and Schamess (2001) utilized a group therapy intervention in a school-based setting using the *Pynoos* model of group therapy developed by Robert Pynoos (Williams, et al., 2001). This qualitative research studied a group comprised of five foster children; three girls and two boys ages 9-11 in an elementary school setting. The group ran for 12-sessions twice weekly. The results were interpreted by the author and in literary fashion described group goals and the experiential component of the group outcome. Key themes that occurred during this intervention illustrated issues such as shame of being in foster care, shame surrounding telling peers in school about being in foster care or involved in the adoptive process as well as

empathic responses around topics of foster care self-disclosures. Furthermore, Williams et al. (2001) reported that self-disclosure of foster care stories was a difficult topic and did not come up until session five, which the author stated is a problem in time limited groups. Reasons for delayed self-disclosures as described by the author's include anxiousness and guarded mood and affect. In addition, the central theme of common experience played a crucial role in building group cohesion, trust and a reduction in feelings of stigmatization of being in foster care placement (Williams et al., 2001).

Mellor and Storer's (1995) study of support groups for children in alternate care argues that many children who are in the foster care system have significant adjustment problems, which manifest themselves in various aspects of their lives. The group intervention took place in a community child welfare agency in a rural setting for four-weeks. The group was comprised of seven participants, between 9-13 years of age and was a mix of foster care children and children residing in residential placement. Although some of their psychosocial histories varied, most were victims of neglect and abuse by one or more parents. A fundamental premise demonstrated in the discussion section noted the bonding and experiential component based on the sharing of out-of-home placement stories. The authors illustrate that sharing their stories allowed the children to realize and gain awareness that they were not the only children going through these traumatic situations and displacements. The conclusion statement of the study indicated successful outcomes and called for further research of this style of intervention. The authors noted the visible changes in the children as well as the value in creating a support network for this population of children and pre-teens (Mellor & Storer, 1995).

Permanency planning is a fundamental goal for all children in the child welfare system (Schwartz & Fishman, 1999). Palmer (1990) authored an article which discusses the placement

breakdown of children in foster care and how group treatment can help in permanency planning. The ACFS [DHHS] (2008) reported that 20-25% of CFC have resided in three or more placements. This frequent displacement and transition can have persistent effects on the psychopathology relating to frequent disorders of adjustment and attachment relationships on CFC (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Forty-six children participated in group treatment which matched CFC to case workers in a social service organization in Ontario, Canada. The groups met for three one and a half hour sessions with the option to have more sessions if agreed upon by both the group members and group leaders. Most groups went to four sessions and a few went to six sessions. Sessions included activities such as talking about separation from birth parents as well as constructing a *Life-History Grid* to organize significant events and transitions. Key themes which were discussed were the notions that the children were not alone in their problems such as having bad dreams or being taken out of their homes. The treatment concluded and illustrated that most CFC will respond to an opportunity to share experiential knowledge and affective responses to their own personal foster care experiences (Palmer, 1990).

Method

The objective of this study was to measure the effectiveness of group psychotherapy as a therapeutic intervention for children in foster care eight to ten years of age. This project assessed the outcomes of a group targeted at providing social skills and support for children in foster care. The intervention was performed in a community outpatient mental health clinic in an urban setting in Western New York. The Strength and Difficulties Questionnaire (SDQ) was administered as an instrument evaluated the progress of the group using a pre-test post-test model. The results of the survey will show the effectiveness of the group intervention on a population of foster care children.

Design

The population of this study consisted of children in foster care placement eight to ten years of age. The sample size consisted of a group of foster care children (n=4). There were two group leaders, which consisted of a licensed social worker and a master's level mental health counseling trainee. The intervention was a 12-week group, which met once a week within the outpatient facilities group therapy room. The orientation of the group was a skill based task group that taught social skills and acted as a counseling group during unstructured conversation to shed light on the foster care experience (ASGW, 1991).

This investigator was not associated as a practitioner performing the group intervention, but collected archival data that was completed by the clinic per their normal pre-test, post-test procedures. The clinic's group leaders administered the questionnaire for the foster parent(s) to complete at session one of the group. The test was also administered to the foster parent's on the last day of group. A foster parent filled out the SDQ. The investigator scored the questionnaires and the data collected by this author to determine the effectiveness of the group intervention on children in foster care. In addition, a T-test comparing the item and sub scale scores was interpreted and the means represented in a pre-test post-test mode in order to show the change in average scores before and after the group intervention.

A data-coding sheet was used to protect the identities of the patients and foster parents associated with the study. The subjects were named and listed as A-D and the SDQ items scored using a numerical system to identify item names and there associated sub-scales.

Assessment Description

The SDQ is a validated and reliable instrument of child psychopathology as well as valid

indicator of social behavior strengths and dysfunctional symptoms and behavior (Becker, Woerner, Hasselhorn, Banaschewski, & Rothenberger, 2004; Goodman, 2001; Goodman & Scott; Warnick, Bracken, & Kasl, 2008).

According to Goodman (2001) the Strength and Difficulties Questionnaire is a one-page questionnaire, which evaluates the psychological functions of children and youth. This writer utilized the parent SDQ questionnaire that was designed for parents and teachers of children ages 4-10 years of age (Goodman, 2001). Copies of the SDQ are in more than 40 languages and are available for commercial use as long as the assessment is not used for financial gain (Goodman, 2005). The SDQ is used for screening as part of a clinical assessment, a research instrument, and is also used to provide outcome measures for different treatment modalities (Goodman, 2001). The SDQ is composed of items some negative and representing deficits in behavior and psychopathology and others indicating strengths of social behavior. There are 25 items organized using a 3-point Likert scale, with five subscales that generate scores for emotional symptomology, conduct problems, hyperactivity-inattentiveness, peer problems and prosocial behavior (Goodman, 2001).

Results

This writer's initial hypothesis was that group interventions are a useful component in the mental health care of foster children. The quantitative data provides initial support in symptoms reduction as well as enhanced changes in social skill development. This change is evidenced by the pre-test and post-test survey scores which were collected at the beginning and the end of the group intervention.

Quantitative Results of SDQ

The results of the group intervention indicate that the intervention did have an effect on all five subscales of the SDQ. Although the results indicated no statistically significant changes pre and post group intervention on the the five subscales of the SDQ, there does appear to be positive clinical change for the group participants (n=4). For ease of interpretation, Tables 1 and 2 provide the mean scores and the standard deviations for the pre-test and post-test subscales of the SDQ. Two subscales on the SDQ, namely *conduct problems* and *total score*, displayed improvement from pre-test to post-test such that scores moved from the borderline to normal clinical range. Although the statistical significance was minor, the clinical change resulted in improvements for the participants in important areas of psychosocial progress, resulting in the reduction of anti-social behavior and an improvement in pro-social interaction.

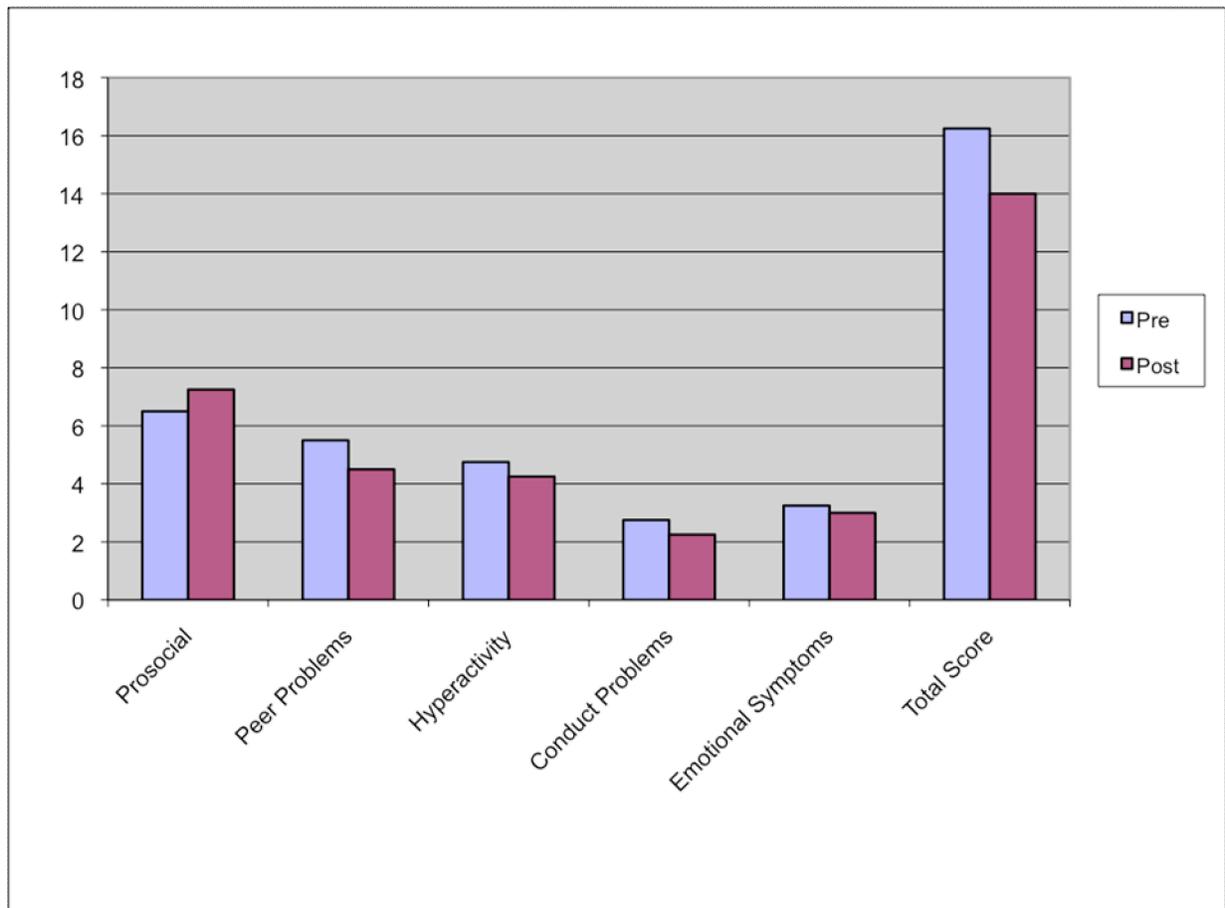
Table 1.

Descriptive Information for SDQ Scales

SDQ Scale	Mean	Std. Deviation	Clinical Range
Prosocial			
Pre	6.50	1.29	Normal
Post	7.25	1.50	Normal
Peer Problems			
Pre	5.50	1.29	Abnormal
Post	4.50	0.57	Abnormal
Hyperactivity-Inatt.			
Pre	4.75	1.70	Normal
Post	4.25	0.95	Normal
Conduct Problems			
Pre	2.75	2.75	Borderline
Post	2.25	2.06	Normal
Emotional Symptoms			
Pre	3.25	1.25	Normal
Post	3.00	1.63	Normal
Total Score			
Pre	16.25	5.00	Borderline
Post	14.00	1.41	Normal

Table 2.

SDQ Subscale Mean Scores

*Prosocial Subscale*

The items representing prosocial behavior on this subscale are described as the following: (a) considerate of other peoples feelings, (b) shares readily with other children, (c) helpful if someone is hurt, upset or feeling ill, (d) kind to younger children, (e) often volunteers to help others. This subscale was significant to the study because increases in prosocial behavior have a parallel relationship with the characteristic of universality and its relationship to cohesion bonding among CFC. The results of the mean scores of this subscale were in the normal range based on the results of the pre test; they remained in the normal range as a result of the post test

but did improve slightly showing a clinical change as a result of the group intervention (see Tables 1 and 2).

Peer Problems Subscale

The items representing symptomatic behavior on this subscale are described as the following: (a) rather solitary, tends to play alone, (b) has at least one good friend, (c) generally liked by other children, (d) picked on or bullied by other children, (e) gets along better with adults than with other children. Group scores fell within the abnormal clinical range for this subscale pre test and were again abnormal on the post test. Although the scores on this scale improved, they remained a clinically significant pathological indicator as described using the SDQ. These findings shed light on the factor of failed attachment relationships and how this component of the foster care experience plays a significant role in interpersonal conflict. Reduction in peer problems is a relevant subscale to this study because of its effect on peer and caregiver relationships, which are often important to placement stability and interpersonal connection among CFC (See Tables 1 and 2).

Hyperactivity-Inattention Subscale

The items representing symptomatic behavior on this subscale are described as the following: (a) restless, overactive, cannot stay still for long, (b) constantly fidgeting or squirming, (c) easily distracted, concentration wanders, (d) thinks things out before acting, (e) see's tasks through to the end. Scores for this subscale fell within the normal clinical range on both the pre-test and the post-test. This scale is often useful for assessing behavioral and symptomatic characteristics of ADHD, anxiety, impulsivity and traits of executive dysfunction. The hyperactivity-inattentive subscale did not rate as a clinically significant problem among this cohort of group participants. (See Tables 1 and 2).

Conduct Problems Subscale

The items representing symptomatic behavior on this subscale are described as the following: (a) often has temper tantrums or hot tempers, (b) generally obedient, often does what they are told, (c) often fights with other children or bullies them, (d) often lies or cheats, (e) steals from home, school or elsewhere. Score on this subscale fell within the borderline clinical range on the pre-test as borderline and then within the normal range on the post-test. This finding indicates decreases in conduct behavior as a result of the group intervention. Conduct behaviors are often associated with distrustful behavior and criminal activity, which are common behaviors among many CFC. (See Tables 1 and 2).

Emotional Symptoms Subscale

The items representing symptomatic behavior on this subscale are described as the following: (a) often complains of headaches, stomach aches or sickness, (b) many worries, often seems worried, (c) often unhappy, downhearted or tearful, (d) nervous or clingy in new situations, (e) many fears, easily scared. Scores for this subscale fell within the normal range on both pre-test and post-test. The emotional symptoms subscale assesses for mood symptoms and emotion dysregulation, and the finding suggests positive clinical change for the population of CFC, although this was not evident by the statistical data. (see Tables 1 and 2).

Conclusion of Quantitative Results

The results of the current study indicate that this group of CFC had the most clinical issues in the subscales of *peer problems* and *conduct problems*. Examples of these problems are evidenced by behaviors such as stealing, lying, aggression, etc. (Goodman, 2001). These behaviors may result in problems such as school suspensions, criminal mischief and

placement instability. The group intervention was successful in targeting these areas of dysfunctional behavior and provided an environment for growth and prosocial interaction.

Discussion

To look back on this foster care epidemic where a half-million children have been separated from primary care givers, often possess unstable home environments and have a predisposition to psychopathology as well as other health care problems, it is surprising that so many of these children raised by our government and human service organizations are able to function in society (Clausen et al., 1998; Garwood & Close, 2001). An intervention such as group therapy offers a milieu of service delivery that enhances care, provides support and offers the experiential component of common cultural characteristics for this minority population of children (Craven, 2008).

The purpose of this research was to assess the usefulness of group therapy on a population of children in foster care. Furthermore, the current paper and its emphasis on group therapy provides a theory of intervention that considers the shared experiences of these children based on their experience in the foster care system. By providing an intervention for this classification of children based upon common experience, this writer hopes to enhance the delivery of care for CFC.

The methods of this study proved to be challenging and the logistical variables played a significant role in hampering the effectiveness of this intervention. Problems of attendance in relation to foster parents sporadically bringing children to appointments as well as medical transportation difficulties provided by adjunct agencies proved most difficult and provided many problems with group attendance. In addition, group leaders reported that guarded affect and presentation made getting to significant issues difficult and the group leaders had to introduce

topics to elicit difficult conversation and self-disclosures (i.e. conversation about biological families). In addition, the small sample size provided a small range of quantitative data to be compared and correlated.

The results of the study suggested that positive clinical change occurred in the foster care children, although not reaching statistical significance, as a result of the 12-week group therapy intervention. The quantitative data provides initial support for this author's hypothesis regarding the improvement of psychosocial properties and symptoms reduction as result the group intervention.

Discussion of the Literature

Attachment

Children in foster care who have been through attachment disruption are often anxious and therefore adapt in ways to suit their needs of security by acting in ways which get them the attention and security they crave in the moment (Howe, 2006). It is often observed that CFC who have endured attachment disruption are keen observers of situations and can be the most astute observers of behavior because their survival and needs of security depend on those around them, most specifically the ones who may be caring for them (Bowlby, 1988).

An attachment difficulty which plagues many children in foster care is the notion of *ambivalence*. Ambivalent feelings are often a central theme of groups with CFC having to do with the possible neglectful and abusive actions taken by care givers. Many CFC state that although primary (i.e. biological) caregivers may abuse or neglect them, it is often illustrated that they possess a conflicting sense of loyalty and connection to those that may have hurt them physically and/or psychologically. Support and restorative efforts have to be implemented to educate parents how to emotionally be aware of children's socio-emotional needs and develop

appropriate support and communication around the need to foster an environment of healthy growth and development (Howe, 2006).

For CFC, it is essential for placement providers to foster youth with well-trained caregivers and community providers who are attuned to the needs of CFC and can nurture the socio-emotional needs of these children who are developmentally broken (Howe, 2006). The adaptive strategies and failure to thrive from a physiological and psychological standpoint, determines that the deficiencies and coping skills developed by dysfunctionally attached infants and children will project character traits demonstrating trust issues. Additionally, these children may seek out improper or dysfunctional caregiving because in fact that is all they know and have been exposed to (Howe, 2006). In conclusion, it is fair to say that being from a broken or chaotic environment will make one more susceptible to developing into a person who seeks out consciously or unconsciously a chaotic, often unstable environment.

Multicultural competence

Multicultural Competence in this writer's research is more than just becoming accustomed to and aware of different races and ethnicities, but the awareness of culture as it applies to every distinct person and the situation or environmental factors, which help shape their existence. In addition, groups may be more than just culturally diverse or exclusive but can be exclusive based on the parameters of pathology. Cancer and AIDS support groups are a prevalent mode of therapy within the health profession. Why not then base groups on certain experiences as a medium to bring about change and verify group outcome studies? White, Black, and Hispanic are traits of ethnic identity. What happens when a child grows up without knowledge of their biological family and grows up instead with a family of a different race, culture and religious identity? The Foster Care Child then becomes inately identified by his placement and

his/her identity as a foster care child. That is what this writer terms as *Cultural Experience*. Cultural experience is the traditions, values and ethos of your experiential environment and the way that it shapes personality and human development. The stigmatization of being a foster child creates a cultural identity that is tangible based upon common familiarities and this identity acculturates itself into the dynamics of a CFC group psychotherapy identity. Therefore, being a foster care child is a culture of its own and can assist in the cohesion and forming processes such as the therapeutic factors of universality and the notion of group cohesion posited by Yalom and Leszcz (2005).

Therapeutic factors of group therapy with CFC

The notion of universality is the most prevalent therapeutic factor in group therapy for CFC. This writer's hypothesis is centered on the idea that when children learn that there are others out there with similar experiences to their own, it opens up a floodgate so that the creation of other factors are made possible such as self-disclosure, altruism and installation of hope etc. (Yalom & Leszcz, 2005). It is an important task of the group leader to foster a sense of universality of similar experience among group members as it leads to a sense of cohesion among group members (Donigian & Malnati, 1997). Yalom and Leszcz (2005) describe the concept of universality as:

Many individuals enter therapy with the disquieting thought that they are unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses, and fantasies. Of course, there is a core of truth to this notion, since most clients have had an unusual constellation of severe life stresses and are periodically flooded by frightening material that has leaked from their unconscious. (p.6)

This statement which Yalom and Leszcz (2005) wrote summarizes a lot of the general and more extreme life stresses that play an intricate role in the lives of CFC. Developmentally, children may not be at a place to generalize and think introspectively. They may therefore experience therapeutic factors of group therapy differently than those who are older and have more life experience (Shechtman & Gluk, 2005). The concept of universality plays a significant role in providing CFC an ethos which suggests that “I am not alone. I am in fact part of a larger network of people who have similar problems” and experiences. The notion of universality may cause a client or child to feel less socially isolated.

One of the group leaders in the study recorded positive statements that the CFC said in regards to experiential conversation they had throughout the course of group. Some of those statements are as follows: “Oh, you’re in foster care too?” “That has happened to me, too.” These comments provide evidence for the notion of universality and were accounts that contributed to the cohesion and bonding of the group. The following are other studies of groups with children in foster care that displayed the benefit of universality among participants of CFC. Williams et al. (2001) utilized a group therapy intervention in a school-based setting using the Pynoos model of group therapy with a population of CFC. The author stated that the central theme of this therapy group is that common experience played a central role in building group cohesion, trust and a reduction in feelings of stigmatization of being in foster care placement. Palmer (1990) discusses placement breakdown of children in foster care and how group treatment can help in permanency planning. The end-result of group treatment concluded and illustrated that most CFC will respond to an opportunity to share empirical knowledge and affective responses to their own personal foster care experience (Palmer, 1990). Furthermore, Mellor and Storer (1995) utilized support groups for children in alternate care and argued the fact

that many children who are in the foster care system have significant adjustment problems. They noted the visible changes as well as the value in creating a support network for this population of children and pre-teens. In addition, they indicated a central theme demonstrated in the discussion section, which noted the bonding and experiential component based on the sharing of out-of-home placement stories (Mellor & Storer, 1995).

Foster care prevention and intervention

This author will speak about the need for foster care prevention and intervention among this at-risk group of children. The group modality of service delivery addresses the needs of a targeted intervention as well as a preventative measure to avoid the possibility of future-oriented psychopathology and negative environmental situations with CFC. Group therapy offers a prosocial milieu of service that in a social context benefits children's social interactions and improves interpersonal communication. In addition, this mode of therapy is helpful in decreasing at-risk behavior and improving socio-emotional skills (see Table 1. and Figure 1.).

Craven and Lee (2006) evaluated eighteen empirically based studies that synthesized the research and intervention strategies for children in foster care. They concluded that out of all the studies which were evaluated, none addressed the uniqueness of the family dynamic for CFC. The studies overall conclusion was a call for more research based upon the need for evidenced based intervention/prevention techniques for CFC which encompasses most of the social service/child welfare population (Craven & Lee, 2006). Garwood and Close (2001) researched the importance of psychological screening for children in foster care. The results indicated that there is a definite need for a battery of testing to assess the population of CFC because of their high-risk of pathological concerns, co-occurring disorders and dysfunction in personality development (Garwood & Close, 2001). CFC often have other health related concerns other than

psychological problems. Chernoff et al. (1994) studied the health care problems of children entering the foster care system. The results indicated that three quarters of CFC had a family history of mental illness and substance abuse. In addition, of the children that were evaluated under the age of five, a quarter of the studied population had abnormal or suspect results on developmental screening exams (Chernoff et al., 1994).

By addressing at-risk behavior and implementing a group mode of care, practitioners attend to both current problems and stressors among a child population. Furthermore, practitioners can provide preventative social skills and influence prosocial behavior, which helps children make better choices and cope better with everyday situations, life transitions and placement stability. In addition, by addressing these problems as children it helps them throughout their developmental journey. By implementing group therapy with CFC early in childhood development, they're more apt to succeed later in life, by doing better in school, at home and can become more successful into young adulthood (Hines, Merdinger, & Wyatt, 2005).

Call for Research and Implementation of Group Therapy with CFC

There is little research on the effectiveness of group psychotherapy for children in foster care (Craven & Lee, 2006; Mellor & Storer, 1995; Williams, Fanolis, & Schamess, 2001). There is limited empirical data and research that proves the effectiveness of group therapy as an intervention for children in foster care (Craven & Lee, 2006). To date, only one quantitative study that illustrates the effectiveness of group therapy with children in foster care has been published. In addition, there are several studies which look at the effectiveness of group therapy with children in foster care. They include a handful of qualitative research that provides valuable intervention techniques but lacks in empirical data and therefore lacks the efficacy to be

considered effective EBP. Proper EBP is important due to third-party insurance and governmental agency reimbursement of services rendered (Whaley & Davis, 2007).

School groups are often a main avenue to provide group therapy services for children (Kulic et. al., 2004). One could make the argument that school psychotherapy groups hinder the learning of academic coursework because it may take the children out of their classroom. One could also make the argument that a balanced child with socio-emotional skills and support is better equipped and may be more apt to function and be successful within a school environment (Kulic et al., 2004). Therefore it makes sense to provide these services in the one place where children reside for 6-8 hours per day, in the schools.

More empirical research is needed in this field to make group therapy standard practice among the many social service, non-profit and governmental agencies that work closely with children in the foster care system. CFC are resilient in nature but further traumatization and negative choices will continue to make this population unsuccessful and dependent on the systems which are pervasive caretakers for these individuals. Furthermore, it is recommended that this intervention become implemented as it plays a significant factor in healing and intervening in the primary, secondary and tertiary characteristics of society and the population of CFC.

Final Conclusion

As we develop as a field of human service and medical professionals it should be evident more so now than before that mental health plays a significant role in the many facets of today's society. Treating attachment disruption should be at the forefront of this pandemic especially as we discover the neurobiological factors that effect young children and persist into adulthood (Hines et al., 2005). CFC more than any other population of children are the ones who are at the

highest risk for health related and environmental stress and dysfunctionality (Clausen et al., 1998; Garwood & Close, 2001). It is imperative that human service and medical professionals recognize this pandemic of environmental stress and its effects on the health and well being of CFC. Furthermore, action must be taken to intervene by providing customized culturally competent care to this population of at-risk children.

My research concludes that group therapy with foster care children is a powerful and evidenced based practice of care to serve the population of at-risk youth. This intervention warrants further investigation but it is conclusive throughout the research, both quantitative and qualitative, that this mode of practice is successful in working with this population of children.

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Appendix A

Institutional Review Board, The College at Brockport

1. Name of Investigator: Joshua E. Maldonado, Graduate Student

Department: Counselor Education

2. Project Title: “Using Group Therapy to Improve the Well-Being of Children in Foster Care”

3. College Status: Graduate Student

4. Faculty /Staff Supervisor's name:

Thomas Hernández, Ed.D., LMHC
Faculty Advisor, The College at Brockport State University of New York
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The College at Brockport Institutional Review Board
Kristin Dauenhauer
IRB Coordinator
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5. Category 1 (Exempt Review)

6. Principal Investigator: I certify that: 1) the information provided for this project is accurate; 2) no other procedures will be used in this project; 3) any modifications in this project will be submitted for IRB approval prior to use; 4) I have successfully completed the required online IRB training program.

Signature of Investigator Date

B. Faculty/Staff Supervisor: 1) I certify that this project is under my direct supervision and that I am responsible for insuring that all provisions of approval are complied with by the principal investigator. 2) I have successfully completed the required online IRB training program. 3) My signature indicates I have reviewed this proposal and agree it is in final form and ready to be submitted to the IRB.

Signature of Investigator Date

1. Project Description

There is little to no research on the effectiveness of group psychotherapy for children in foster care. Youth in foster care are an at-risk population, who generally are more vulnerable to issues including neglect and abandonment as well as a predisposition for developing mental health problems mental health from first generation biological parents. “ Although not definitive, there is considerable literature supporting the allegation that children inappropriately deprived of family life and kept in foster care and institutions for extended periods end up in mental health caseloads and in jails more frequently than those with more stable family histories” (Gurak, Smith, & Goldson, 1982).

The objective of this study is to measure the effectiveness of group psychotherapy as a therapeutic intervention for children in foster care six to ten years of age. This project will assess the outcomes of a group targeted at providing social skills and support for children in foster care. The intervention will be performed in a community outpatient mental health clinic in Rochester, NY. The Strength and Difficulties Questionnaire (Goodman, 2005) will be administered as an instrument that will evaluate the progress of the group using a pre-test post-test model. By administering this anonymous survey, the investigator will be able to show the effectiveness of the intervention.

The investigator will not be associated with the study as a practitioner performing the group intervention, but will collect archival data that will be completed by the clinic per their normal pre-test, post-test procedures. The clinic's group leaders have already administered the questionnaire for the foster parent(s) to complete at session one of the group. The test will also be administered on the last day of group.

2. Number of and the relevant characteristics of subjects.

The population of this study consists of children in foster care placement ages six to ten years of age. There will be anywhere from three to six group participants partaking in the intervention. At least one or more foster parents will fill out the Strength and Difficulties Questionnaire (Goodman, 2005). The group leaders will score the questionnaires and the data will be collected by this investigator to determine the effectiveness of the group intervention on children in foster care.

3. Subject Selection

The subjects of this study are chosen based upon their participation in a selected group, which targets children in foster care at an Outpatient Mental Health clinic in Rochester, NY. The subjects are referred to this group from local agencies, including social service agencies and mental health agencies.

4. Research Assistants

There will be no research assistants included in this project.

5. Funding

No funding is necessary for this project

6. Date of Project

The research project will begin upon review and approval of the IRB and will be completed by May 8, 2009.

7. Questionnaire

Attached

8. Online Training Course

The investigator for this project has completed and passed the online training course and proper documentation is attached.