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The Effectiveness of Transitional Group Therapy: Promoting Resiliency in Foster Children

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THE EFFECTIVENESS OF TRANSITIONAL GROUP THERAPY:
PROMOTING RESILIENCY IN FOSTER CHILDREN

By

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This dissertation is dedicated to all the foster children who have silently inspired me to complete this dissertation. Their courage and diligence has guided me to focus on my life’s work.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>vii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>viii</td>
</tr>
<tr>
<td>Abstract</td>
<td>ix</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>1</td>
</tr>
<tr>
<td>2. REVIEW OF LITERATURE</td>
<td>3</td>
</tr>
<tr>
<td>Foster Care</td>
<td>3</td>
</tr>
<tr>
<td>The Foster Care Experience</td>
<td>4</td>
</tr>
<tr>
<td>Developmental Concerns for Children in Foster Care</td>
<td>5</td>
</tr>
<tr>
<td>Social Skills and School Performance</td>
<td>6</td>
</tr>
<tr>
<td>Stigmatization of Foster Children</td>
<td>7</td>
</tr>
<tr>
<td>Conclusion</td>
<td>7</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>8</td>
</tr>
<tr>
<td>Conclusion</td>
<td>13</td>
</tr>
<tr>
<td>Current Foster Care Interventions</td>
<td>14</td>
</tr>
<tr>
<td>Treatment</td>
<td>17</td>
</tr>
<tr>
<td>Rationale for Current Study</td>
<td>20</td>
</tr>
<tr>
<td>Conclusion</td>
<td>23</td>
</tr>
<tr>
<td>3. METHOD</td>
<td>24</td>
</tr>
<tr>
<td>Research Questions</td>
<td>24</td>
</tr>
<tr>
<td>Testable Hypothesis</td>
<td>25</td>
</tr>
<tr>
<td>Definitions</td>
<td>25</td>
</tr>
<tr>
<td>Research Assumptions</td>
<td>26</td>
</tr>
<tr>
<td>Theoretical Assumptions</td>
<td>26</td>
</tr>
<tr>
<td>Participants</td>
<td>27</td>
</tr>
<tr>
<td>Demographics of Group Participants</td>
<td>27</td>
</tr>
<tr>
<td>Implementation Evaluation</td>
<td>29</td>
</tr>
<tr>
<td>Outcome Effectiveness of TGT as Implemented</td>
<td>30</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>31</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>33</td>
</tr>
<tr>
<td>4. RESULTS</td>
<td>35</td>
</tr>
<tr>
<td>Part I-Feasibility of TGT</td>
<td>35</td>
</tr>
<tr>
<td>Getting an Agency Involved</td>
<td>35</td>
</tr>
<tr>
<td>Recruiting Group Members</td>
<td>38</td>
</tr>
<tr>
<td>Recruiting TGT Staff</td>
<td>39</td>
</tr>
<tr>
<td>Barriers to Implementation</td>
<td>40</td>
</tr>
<tr>
<td>Training Program Staff</td>
<td>41</td>
</tr>
<tr>
<td>Treatment Fidelity</td>
<td>42</td>
</tr>
<tr>
<td>Completion of TGT and Mortality</td>
<td>43</td>
</tr>
<tr>
<td>Conclusion</td>
<td>43</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Part II-Investigation of Therapeutic Potential of TGT</td>
<td>44</td>
</tr>
<tr>
<td>Treatment Outcome</td>
<td>44</td>
</tr>
<tr>
<td>Themes of Group Sessions</td>
<td>48</td>
</tr>
<tr>
<td>Conclusion for Qualitative Results</td>
<td>57</td>
</tr>
<tr>
<td>Quantitative Results</td>
<td>57</td>
</tr>
<tr>
<td>Conclusion of Quantitative Results</td>
<td>65</td>
</tr>
</tbody>
</table>

5. DISCUSSION

| Part I-The Feasibility of TGT                     | 68 |
| The Potential Promise of TGT                      | 69 |
| Strengths of the Study                            | 71 |
| Contributions to the Field                        | 74 |
| Part II-Limitations of the Study                  | 74 |
| Additional Revisions                              | 77 |
| Final Conclusions                                 | 79 |

APPENDICES

| A. Logic Model                                    | 80 |
| B. Transitional Group Therapy Manual              | 82 |
| C. Letter of Endorsement from Children’s Home Society | 88 |
| D. Human Subjects Committee Approval FSU          | 90 |
| E. Human Subjects Committee Approval DOH          | 92 |
| F. Parent Informed Consent                        | 95 |
| G. Foster Parent Informed Consent                 | 97 |
| H. Child Assent                                   | 99 |
| I. TGT Certificate of Completion                  | 101 |
| J. Case Studies                                   | 135 |

REFERENCES

| 116 |

BIOGRAPHICAL SKETCH

| 125 |
LIST OF TABLES

Table 1. Demographics of Group Participants 29
Table 2. Descriptive Statistics of CBCL 58
Table 3. Wilcoxon Signed Ranks Test-Anxious/Depressed 59
Table 4. Test Statistics for CBCL-Anxious/Depressed 59
Table 5. Wilcoxon Signed Ranks Test-Rule-Breaking Behavior 60
Table 6. Test Statistics for CBCL-Rule-Breaking Behavior 60
Table 7. Wilcoxon Signed Ranks Test-Aggressive Behavior 61
Table 8. Test Statistics for CBCL-Aggressive Behavior 62
Table 9. CBCL Subscales Test Statistics 62
Table 10. Descriptive Statistics for BERS subscales 63
Table 11. Test Statistics for BERS Subscales 63
Table A1 Logic Model 81
Table J1. CBCL Results for David 106
Table J2. BERS Results for David 106
Table J3. CBCL Results for Amy 109
Table J4. BERS Results for Amy 110
Table J5. CBCL Results for Mark 114
Table J6. BERS Results for Mark 114
<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resiliency and TGT Intervention</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>Kim’s Self Portrait</td>
<td>55</td>
</tr>
<tr>
<td>J1</td>
<td>David’s Self Portrait</td>
<td>105</td>
</tr>
<tr>
<td>J2</td>
<td>Amy’s Sand Tray</td>
<td>108</td>
</tr>
<tr>
<td>J3</td>
<td>Mark’s Self Portrait</td>
<td>112</td>
</tr>
<tr>
<td>J4</td>
<td>Mark’s Sand Tray</td>
<td>113</td>
</tr>
</tbody>
</table>
ABSTRACT

There are currently over 500,000 children in foster care in the United States. Foster care places them at a high risk for immediate and long term psycho-social-educational problems. In an effort to prevent some of the immediate behavior problems in foster children, an innovative intervention referred to as Transitional Group Therapy (TGT) was developed. TGT combines developmentally appropriate therapeutic interventions, psycho-education, and play therapy in a group milieu to facilitate resiliency. This study is the first phase of a best practices approach in which TGT was tested for its feasibility with 11 first-placement foster children, ages 6-11. Its research and development methodology employed both qualitative and quantitative methods. A challenge to the implementation of this program included systemic barriers to recruiting participants. Qualitative data and quantitative pre and post testing on the Child Behavior Checklist and the Behavior and Emotional Rating Scale offered promise of the TGT’S effectiveness. This preventive intervention in time may be viewed as providing a “shot in the arm” to instill resiliency in first-placement foster children to help them survive their experience.
CHAPTER 1
INTRODUCTION

The number of children in foster care has increased over the years. It is currently estimated that over 500,000 children are in foster care in the United States (Haury, 2000). Although intended to rescue children from adverse developmental circumstances, foster care itself has been empirically associated with negative influences on development. These are thought to be overlaid upon and to exacerbate those adverse influences prior to foster care, namely, risk factors associated with poverty, such as inadequate access to prenatal care, homelessness, and limited educational opportunities. This combination of adverse contextual circumstances, parental neglect and/or maltreatment, and indefinite stays in foster care is a bio-psycho-social stew the ingestion of which increases the probability of long-term health problems, including chronic mental and behavior problems and developmental disabilities (Haury).

The initial placement for the foster child has been found to be a very traumatic and a difficult time consisting of multiple transitions (e.g. home, school, church, and friends) (Clausen, Landsverk, Ganger, Chadwick, & Litonwnik, 1998). As is true of so many diverse potentially toxic environments, not all inhabitants of foster care fare the same. There are individual differences ranging from success stories to tragedy. Nevertheless, little has been written, and less empirically tested, about how these predictable deleterious influences may be moderated when children are initially placed in foster care. How well children survive foster care – or make use of it -- may be a function of how resilient they are.

The first step in ameliorating the iatrogenic affects of foster care was to investigate agents found to cultivate personal resiliency in other populations of children and apply them to children early after they have been placed in foster care. Transitional Group Therapy (TGT) was built on the concept of promoting resiliency in children during their first initial placement in foster care. The theoretical framework incorporated a developmental and resiliency approach.

Purpose of the Study

The purpose of this dissertation research included three primary elements:

1. Development of a best practices intervention -- namely, Transitional Group Therapy (TGT) -- to provide an immediate increase in personal resiliency for first placement foster children;
2. An attempt to implement TGT in order to identify barriers and to investigate the implementation process;

3. Use of qualitative data and pre-and post-testing of participants to get a sense of the promise of TGT as a foster care intervention.

   Transitional Group Therapy is a short-term intensive group therapy designed by this researcher to embody what has been considered to be the central aspects of resilient relational systems, that is, features of social relationships that buffer members from stress while helping them become more resilient to future stressors. The primary treatment goal of TGT is to provide an immediate increase in personal resiliency in children initially separated from their primary caregivers. By promoting resiliency in these children TGT is expected to prevent short-term behavioral problems in children separated from their primary caregivers. It is this researcher’s hope that such immediate amelioration of adjustment problems and the development of coping skills may inhibit the cumulative growth of negative bio-psycho-social outcomes for foster children relative to children not in foster care. This research is a feasibility study and testing of this hypothesis is beyond the scope of this primary investigation and the initial goals of this study are much more limited. Using a mixed method approach, quantitative and qualitative methods have been employed to merely explore the possibility and potential effectiveness of TGT.

   TGT uses a resiliency framework to address specific issues children experience on first placement. TGT was developed based on the research and development (R & D) tradition (Bischoff, McKeel, Moon, & Sprinkle, in Sprinkle & Moon, 1996). This approach typically blends qualitative and quantitative research and includes the following plan:

1) Determining a need

2) Planning a strategy for filling that need

3) Developing a preliminary model of the strategy

   To develop an appropriate intervention it was important to review literature that included foster care experiences, theoretical frameworks, and current therapeutic interventions for foster children. These then needed to be translated into a testable intervention, in this case, TGT.
CHAPTER 2
REVIEW OF THE LITERATURE

Foster Care

The overall goal of family foster care is to provide a planned, time-limited, substitute family placement for children who cannot adequately be cared for at home (Baum, Crase, & Crase, 2001). The early development of foster care began with the church boarding abandoned children with worthy widows. Indenturing children to apprentices was also a historical practice. The first act of indenturing of children to foster care was due to poverty. Parents who could no longer afford to care for their children entered their child in an apprenticeship with a master until they reached the age of twenty-one. Children received room and board for their work. Charles Loring Brace developed the current foster care system in the mid nineteenth century as a temporary welfare system that provided emotional and economic support to children whose parents were unable to care for them.

The purpose of foster care has evolved to provide a child with a stable, non-institutionalized environment when a child’s parents cannot properly minister to their emotional, physical, and economic needs. In the present foster care system, states place foster children into the foster care system using two methods of placement; voluntary, and involuntary. This temporary placement is meant to be short-term until reunification with parents is achieved. However, contrary to reunification goals, children often remain in the custody of the state for several years (Haury, 2000; Lee & Lynch, 1998).

The Scope of the Problem

Evaluating the trends of foster care reveals a consistent increase in children removed from their primary caregivers. In fact, the foster care population has doubled since 1962, and has gradually increased over the years from 400,000 in 1990 to 570,000 in 1999 before dropping to 523,000 by 2003. Trends indicate that the rate of children living in foster care increased from 6.2 per 1000 children in 1990 to 8.1 per 1000 in 1999, before decreasing to 7.2 per 1000 in 2003. (US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children’s Bureau, 2006).

There have been several factors that have contributed to children entering foster care. Factors such as AIDS, rising rates in drug abuse and homelessness may be compromising family stability. The child abuse and neglect reporting and intervention laws implemented in the past
decade may have also attributed to this increase in out-of-home care for neglected and abused children due to mandatory reporting by professionals and children needing immediate shelter. Declining informal and extended family supports, and other social forces may also be undermining the resiliency and the coping capacity of families (Freundlich, 1997).

Moreover, children are remaining in foster care longer than in the past, averaging 30 months in the District of Columbia, 35.6 months in Illinois, and 32.1 months in New York (Barbell & Freundlich, 2001). It is estimated that the longer the child stays in foster care the more likely the child will have multiple placements (Barbell & Freundlich) and the more placements a child incurs the more problems they are likely to develop (Fanshel, Finch, & Grundy, 1989). Also, researchers found a direct relationship between the numbers of placements children experienced and the level of hostility they displayed (Fanshal, Finch, & Grundy). According to Haury (2000), children are left for extended periods in foster homes and find themselves getting lost in the system that was created to provide them with protection. In an attempt to assemble all the necessary facts to develop and implement an effective intervention for foster children, this preliminary study includes a literature review on the following subjects:

1. The foster care experience
2. Theoretical framework
3. Current foster care interventions
4. The translation of these data into a “best practices’ intervention incorporating group therapy, play therapy, and psychoeducation.

The Foster Care Experience

Child Maltreatment Prior to Foster Care.

Epidemiology. The high prevalence of mental health problems among children in foster care is well-documented (Clausen, Laudsverk, Ganger, Chadwick, & Litronwnik; 1998; McIntyre & Kessler, 1998; Pilowsky, 1995; Stein, 1997). To complicate the exploration of the effects of foster care placement on children, the majority of these children have been abused or neglected prior to entering foster care (Stein). Another possibility is the amalgamation of maltreatment and the separation from their family; one factor exacerbating the other. Maltreatment involving abuse and neglect poses grave risks for foster children. In order to protect children from maltreatment, removal from their parent’s home is often necessary, but
removal may be in itself traumatic. Children who have been removed from their homes due to neglect or maltreatment may enter out-of-home care in a vulnerable and confused state.

**Prodromal circumstances.** There are a variety reasons children may be placed in foster care. Injurious factors include, neglect, substance abuse, parent incarceration, physical abuse, sexual abuse, child’s behavior, abandonment, inadequate housing, truancy, caretaker illness, parent death, and many others. There are many determinants of child maltreatment. The child is embedded in multiple systems that interact with one another to contribute to child outcomes. Child maltreatment may be based on a disturbed parent-child relationship rooted in parental, family, environmental, and child determinates. Since child maltreatment often goes unnoticed until prior to the child entering out-of-home care, it is difficult to determine the etiology of psychopathology when a child develops behavior problems while in foster care (Ambert, 1997).

**The presence of psychic trauma.** Psychic trauma is a common consequence of the events leading to foster placement. Foster children often experience trauma on multiple levels as a result of neglect or abuse. Twenty-two percent of foster children of all ages were reported to suffer severe posttraumatic stress symptoms (Perry, Pollard, Blakley, & Vigililante, 1995). Children exposed to trauma may have a wide range of symptoms such as posttraumatic stress disorder (PTSD), behavior disorders, anxieties, phobias, and depressive disorders (Perry, Conrad, Dobson, Schick, & Ryan, 2000). Dale, Kendall, & Sheehan (1999) screened 152 foster children between the ages of six and eight for PTSD and one-third met the criteria. This includes children who have witnessed violent crime, experienced abuse, separation from caregiver, and other traumatic experiences. The majority of foster children have at least one psychiatric disorder, and approximately 33% have three or more diagnosed psychiatric problems (dosReis, Zito, & Safer, 2001). Trauma unacknowledged in foster children may express itself in the development of internalizing (e.g. depression, anxiety) or externalizing (e.g. aggression, hyperactivity) disorders (Perry et al., 1995). Because trauma symptoms are often expressed intrapsychically and behaviorally in ways that interfere with learning; poor school performance is often a result (Williams, Fanolis, and Schamess, 2002).

**Developmental Concerns for Children in Foster Care**

**Developmental Dysfunction**

Foster care itself may negatively impact foster children’s immediate and long-term development. In a review of studies using clinical assessments and standardized measures,
children in foster care were found to be at risk for emotional, behavioral, and developmental disorders two and one-half times the rate in the general population (Garwood & Close, 2001).

Dubowitz (1990) found that foster children were three to six times more likely to experience emotional, behavioral, and developmental problems than children not in care. A 1984 study of foster children in New York found that 40% of the children in foster care manifested emotional and behavioral problems, including thought disorders, paranoia, suicide attempts, eating disorders, self-abuse, and attention deficits (Ingall, Hatch, & Meservey, 1984). Landverk and Garland (1999) estimate that between one-half and two-thirds of foster children have behavioral or emotional problems. Sexual acting out and hostile behaviors along with numerous other mental health concerns were found in a study in California (Fitzharris, 1985).

Foster children who age-out of foster care instead of returning home have accumulated a set of problems that make transition to adulthood difficult. According to a national study of youth aging out of foster care, 38% were emotionally disturbed, 50% had used illegal drugs, and 25% were involved with the legal system. Only 48% had graduated from high school at the time of discharge (Vandivere, Chalk, & Moore, 2003). Children who spent long periods of time in multiple foster care homes were more likely than other children to experience problems such as unemployment and homelessness (Courtney & Piliavin, 1998).

Studies have revealed foster children experience numerous physical health problems ranging from dental caries (Silver, Haecker, & Forkey, 1999) to high rates of chronic medical conditions and physical growth disorders (Chernoff, Combs-Orme, Risley-Curtis, & Heisler, 1994). In a New York study, one-third of adolescents discharged from foster care ended up on public assistance within 15 months (Moynihan, 1988). Yet another study in California revealed that two-thirds of inmates had been in foster care (Moynihan). Many foster youth end up homeless, without social and work skills needed to survive independently. Chernoff and colleagues (1994) found that more than 50% of three-year-old foster children in their study needed referrals for mental health services. Due to multiple contextual factors that may have contributed to these unfortunate statistics it is difficult to differentiate if the contributing factors may have occurred prior to foster care and exacerbated by foster care placement itself.

**Social Skills and Academic Performance**

The developmental of friendships are paramount for elementary school children. Due to possibility of multiple foster home placements and transferring to different schools, the
emotional drain can affect the quality of foster children’s schoolwork. Studies of maltreated children in foster care have shown higher rates of learning disabilities (10%; Nasstrom & Koch, 1996; 40%; Stein, 1997) and achievement problems (41%; Chamberlain, Moreland, & Reid, 1992) and adaptive behavior deficits (73%; Horowitz, Simms, & Farrington, 1994). The emotional trauma of transitioning to foster care can interfere with cognitive abilities (Rosenfeld et al., 1997). Common problems in school are falling behind academically, failing classes, failing to do homework, cheating, and disrupting class (Rosenfeld et al., 1997; Stone & Stone, 1983).

Stigmatization of Foster Children

Due to stigmatization, foster children may be picked on by classmates, develop school phobia, or engage in truancy (Noble, 1997). Many children who are placed in foster care feel that they have been removed due to a wrong doing on their part. The result is guilt and feelings of stigmatization, loss, and powerlessness. This can lead to children being overly demanding or overly compliant in relationships with adults (Williams, Fanolis, & Schamess, 2002). Shame has also been a central theme of qualitative studies (Williams et al., 2002; Whiting & Lee, 2003). Results of a school-based group designed for foster children revealed that group members were replete with direct and indirect references to shame and stigmatization. They may be ashamed that their biological parent(s) were unable to care for them and they may be ashamed of peer reactions to their experience. Results also indicated that foster children made direct and inferred references to shame and stigmatization in their group therapy (Williams et al.). Because power is the main element of stigmatization, foster children may feel powerless when they find themselves in unfamiliar surroundings. In a recent review by Blower and colleagues (2004), found that foster children assert they were being stigmatized for being in foster care and they were concerned that a label of mental illness might stigmatize them further.

Conclusion

It may be important to identify the factors that place foster children at-risk for challenges that need to be addressed early in placement. These factors may contribute to the development of emotional or mental health disorders. It begs the question of how a child could possibly survive the numerous issues while experiencing foster care. While foster children face significant deficits to their growth and development, some children thrive despite their challenges. This serves as an important element to explore in promoting resiliency in foster children.
Theoretical Framework

Theoretical constructs integrated within the framework of this study were developmental theory, attachment theory, and resiliency theory. Critical periods exist for children that include the importance of development, attachment, and interaction among physical, psychological, social, and environmental factors. How we handle these critical periods may determine how resilient we are. Resiliency may be defined as the ability to bounce back despite life’s challenges (Rutter, 1985). In addition, being resilient may suggest that children are capable of discovering on their own their need to help and be of service, to feel important, to have a dream, and to touch the hearts of others. Developmental, attachment, and resiliency may work in sync with each other in children to guide and direct their path in life.

Developmental Theory

Knowledge of normal child development and family functioning helps identify children receiving insufficient and inappropriate care as well as children who are victims of or a risk for abuse or neglect (American Academy of Pediatrics, 2001). Basic stimulation techniques and stable predictable nurturance may be necessary during these critical periods to enable optimal cognitive, language, and personal socialization skills. The support they require is reparative as well as preventive.

Developmental issues that are important to young children in foster care include: (a) the implications and consequences of abuse, neglect, and placement in foster care and early brain development; (b) the importance and challenges of establishing a child’s attachment to caregivers; (c) the importance of considering a child’s sense of time in all aspects of the foster care experience; and (d) the child’s response to stress. The foster child is faced with the task of adjusting to normative tasks while transitioning to a new home environment. Childhood is characterized by change, transition, reorganization, and involves rapid growth and development. This period of rapid change can contribute to increased vulnerability at this significant time in a child’s life (Hoagwood & Olin, 2002).

Simultaneously, families also go through developmental transitions. According to Carter and McGoldrick (1999), stress is often greatest at transition points from one stage to another in the developmental process as families rebalance, redefine, and realign their relationships. Transitions are a natural part of life. Like many transitions in life there are turning points, uncomfortable periods that mark the beginning of something new while signifying the ending of
something familiar (e.g. marriage, divorce, death, job change). It is during this period of change that children can be so vulnerable, but paradoxically, when personal growth can also occur (Carter & McGoldrick).

According to Erickson’s stages of development, children aged 6 to 12 are dealing with social acceptance by their peers. Rules of social behavior, ideas about caring for others, and a sense of justice and self-esteem are some of the things that children learn from their peers. This developmental period for children is a time that children develop a self-concept and individuality, comparing themselves with their peers. It is during this time that they develop an orientation toward achievement that will color their response to school and other challenges for many years. In this preadolescence stage of development, children have the opportunity to develop competencies, interests, and a healthy sense of confidence so that they can master and control their worlds. It is a vulnerable time and problems with anxiety, low self-esteem, and withdrawal in the face of challenges begin to emerge during this period as children respond to new demands placed on them to which they must adjust (Erickson, 1968).

Although children and families vary greatly in this developmental process, individual human development goes through an expected trajectory of stages depending on the availability of resources, cultural influences, and the period in history in which children grow-up (Carter & McGoldrick, 1999). Typical developmental transitions that family members experience during their lifespan involve changes in family structure, normative tasks of family members at each stage of development, emotional climate within the family, boundaries, patterns of interaction, and communication patterns (Carter & McGoldrick).

A normal child’s development trajectory would include the stability of what will occur from day to day based on the structure of their home life and stability of the family. Adults cope with impermanence by building on an accrued sense of self-reliance and by anticipating and planning for a time of greater constancy. Young children have limited life experience on which to establish self. Their sense of time focuses exclusively on the present and this precludes any meaningful understanding of temporary versus permanence. For very young children, periods of weeks or months are not comprehensible (American Academy of Pediatrics, 2001).

**Attachment Theory**

A healthy attachment style can play a crucial role in the psychological effects of foster children (Haury, 2000). Attachment Theory holds that attachment styles are developed in
childhood and continue to affect the ability to form intimate and healthy relationships as adults (Ainsworth, 1982; 1989). A healthy attachment invokes trust and a secure base for the child to develop. Bowlby (1969) believed that the infant-caregiver relationship forms an internal working model that later influences interpersonal perceptions, attitudes and expectations. This invokes trust and a secure base for the child to develop. Repeated experiences become encoded in our implicit memory as expectations and then as schemas of attachment to create a haven of safety (LeDoux, 1996). Although foster care is intended to provide a safe haven for these vulnerable children, separation from their families can have significant adverse consequences due to unavailability of a familiar caregiver. Even when previous caregivers have not provided adequate care, separations from these caregivers cause children to become deregulated behaviorally and physiologically (Fisher, Gunnar, Chamberlain, & Reid, 2000).

Parent-child separation and the making and breaking of attachments are issues central in the life of a foster child and affect their emotional well-being. Foster children experience ambiguous loss as a result of the removal of significant family members from their internal family structure. Drawing on family systems theory, this ambiguous loss may leave them confused about who is in or out of their internal family system (Gardner, 1996). To develop into a psychologically healthy human being, a child needs a relationship with an adult who is nurturing, protective, and fosters trust and security (Werner & Smith, 1982).

The family dynamics of a foster family is unique unto itself. Each family member must deal with family relationships on a day-to-day basis. Because the family composition changes periodically a child has multiple family disruptions as a result of being placed in foster care. When he or she builds a relationship with either a caregiver or a foster sibling, sometimes this relationship is broken due to a change in placement or reunification with his or her biological family. As a result, a foster child may intentionally disrupt a placement or prevent a positive relationship from developing with the fear that it will end at a moment’s notice.

The foster care system may be problematic to assess attachment relationships by its own nature of complexity. Foster care facilitates the act of disrupted attachments and professionals need to understand thoroughly the consequences of this interruption. Foster parents understanding of the attachment cycle and the subsequent development of disordered attachment are vital if the foster family is going to welcome a challenging child into their home (Wilson, 2001).
Resiliency Theory

When thinking about the positive foster care experiences and outcomes it is impossible to ignore Werner’s (1987) classic observations of the developmental trajectories of ecosystemically challenged children in Hawaiian villages. Some children fell asunder, some got by, and some even thrived. Werner identified a series of individual-interaction with-context traits that would lead to the systematic study of individual and relational “resiliency.” This concept has been applied to children of divorce (e.g., Heatherington, 1999), students of various ages (e.g. Milstein & Henry, 2007), immigrants (e.g. Frommer & Thompson, 1998), and first time parents (Shirilla & Weatherston, 2002)—among others of whom face challenging circumstances.

Given the heuristic value of the concept of resiliency in manifold related settings, it makes sense to extend this concept to children’s adaptations to the challenges of foster care. How well children endure the foster care experience may be a function of how resilient they are. In a recent workshop, world-renowned play therapist Eliana Gill (2005) stated “If we could only identify and bottle resiliency, foster children may have the skills to survive their experience.” It has been asserted that when an individual is faced with stress and challenges, unless they succumb, they will survive, recover, or possibly even thrive. When one thrives, he or she not only bounces back in the face of adversity, but also may surpass previous levels of functioning, and grow and flourish (O’Leary, 1998). The resiliency processes can only take place in the context of risk (i.e. particular problems, challenges, and stressors) (Flynn, Ghazal, Legault, Vandermeulen, & Petricks, 2004). Resiliency emphasizes the natural, self-righting tendencies of individuals who, when given the opportunity and support, succeed against what are sometimes incredible odds. Therefore the relationship between adversity and outcomes may be moderated by protective factors (Gest, Neeman, Hubbard, Masten, & Tellegen, 1993). Resiliency has been defined by authors with a different emphasis on various attributes or factors.

Bernard (1991) described resilient children having four attributes (1) social competence, the ability to elicit positive responses from others, thus establishing positive relationships with both adults and peers, (2) problem-solving skills, the ability to plan, based on seeing oneself in control and on being resourceful in seeking help from others, (3) autonomy, a sense of one’s own identity and an ability to act independently and exert some control over one’s environment, and (4) sense of purpose and future, having goals, educational aspirations, persistence, hopefulness, and a sense of a bright future.
Ambert (1997) describes resilient children having seven common characteristics:

- The ability to form at least one sustaining relationship
- Easy temperament
- Positive self-esteem or sense of competence in dealing with the world,
- Being at ease with people while making others feel comfortable with them
- The ability to get support and encouragement from teachers, relatives, babysitters, and other adults, which can compensate for their parent’s inadequacies
- Minimize their emotional involvement with a dysfunctional parent and have a high degree of independence early in life
- Show a good deal of creativity and originality. These children are able to adapt regardless of conditions such as; abuse, poverty, violence, neglect, negative peer influence, divorce, and multiple moves.

According to Rutter (1987), to promote resiliency in vulnerable children four protective mechanisms must be in place. These include:

- Decreasing risk factors
- Reducing negative chain reactions that heighten risk for sustained impact and further crisis
- Strengthen protective family processes and reducing vulnerabilities
- Bolstering family and individual self-esteem and efficacy through successful problem mastery.

For the purpose of this study this researcher used MacDonald and Valdivieso’s (2000) framework for understanding assets and resilience that relate to a desirable outcome for youth. This researcher believes that this description is holistic in nature due to including health and self-care as a factor, along with volunteerism to promote resiliency. Aspects of these assets have been slightly altered to adjust to resiliency in children vs. adults.

- **Aspects of identity**-self-confidence, connection, commitment to others, self-worth, mastery and future orientation, belonging and membership, responsibility, spirituality, and self-awareness
- **Areas of ability**- physical health, mental health, intellectual, volunteerism as well as cultural abilities
• **Developmental opportunities**-for exploration, expression and creativity, roles and responsibilities such as group membership, contribution and service

• **Emotional, motivational, strategic supports**-nurturance and friendship, high expectations, standards and boundaries, options assessment and planning, and access to resources

The ability to teach resiliency in adults and children has been debated. Many believe that resiliency is innate and not teachable. When reviewing resiliency programs it was discovered that many resiliency programs are school-based. Richardson and Nixon (1997) developed a resiliency-training program to help children avoid the pitfalls of violence, drugs and crime, and at the same time to become happy, productive, and contributing citizens. The resiliency model is a map of human experience that shows how we grow through changes in life (Richardson & Nixon, 1997). The Resilient Youth Curriculum is a discovery of a child’s personal gifts, talents, and strengths that provide their innate resilience that all humans possess. This educational-based model focuses on strengths and potential of youth versus weaknesses and pathology. This model also contributed to the TGT program developed with the purpose of promoting resiliency traits in foster children. This may provide them with preventive tools to help overcome obstacles as a result of their foster care experience.

**Conclusion**

Individual resiliency may be inherent in how people deal with life changes and what they do about their situations based on multiple factors. Over the last decade, various models of resiliency have been proposed; each emphasizing various ecological and psychological contexts (Egeland, Carlson, & Stroufe, 1993). Today the construct of resiliency is considered to be a dynamic developmental process whereby the individual and environmental engages in transactions throughout the lifespan. As a result, resilience is distinguishable from prior conceptualization of the trait-based resiliency (Luther, Cicchetti, & Becker, 2001). A person’s ability of being resilient may also be determined by contextual and environmental factors such as timing and the personal meaning of an event (Rutter, 1985). A person’s response to a stressor may be influenced by his or her appraisal of the situation and his/her capacity to process the experience, attach meaning and incorporate it into his or her belief system (Rutter). This appears to be an important factor when developing a resiliency intervention for foster children.
Current Foster Care Interventions

A systematic research synthesis of empirical studies was conducted in an attempt to identify and classify current therapeutic interventions for foster children (Craven & Lee, 2006). Utilizing a treatment protocol classification system, empirical studies were classified according to their theoretical, clinical, and empirical support. Eighteen studies were reviewed; including a compare/contrast of methodological strengths and shortcomings. Six out of the eighteen interventions were considered well-supported and efficacious, three interventions were determined to be supported and probably efficacious, and nine were supported and acceptable. Interventions recognizing the unique experience of foster children and foster family dynamics were found to be lacking in the current literature (Craven & Lee).

The review of current interventions for foster children focused on the following criteria: (1) treatment used specifically with foster children, (2) interventions that mentioned utilization with foster children, and (3) interventions that targeted children with numerous risk factors. Since the amount of interventions specifically for foster children was sparse, articles that targeted at-risk children were also reviewed to provide possible therapeutic interventions that may be applied to foster children. The studies reviewed varied in their efficacy and an apparent gap was found in the number of evidenced-based effective interventions specifically for foster children (Craven & Lee, 2006).

Three of the interventions used treatment foster care as an overall milieu which involves engaging the foster parent as the therapeutic agent (Chamberlain & Reid, 1998; Fisher, Gunner, Chamberlain & Reid, 2000; Whitemore, Ford, & Sack, 2003). Holding Therapy (Myeroff, Mertlich, & Gross, 1999) and Dyadic Developmental Psychotherapy (Becker-Weidman, 2004) treated attachment disorders. The Foster Care Clinic (Horowitz, Owens, & Simms, 2000), Prenatal and Early Childhood Nurse Home Visitation (Olds, Henderson, & Tatelbaum, 1995), and ENHANCE (O’Hara, Church, & Blatt, 1998) are three interventions that involved developmental screening, along with medical and mental health screening. Four interventions focused on the prevention of out-of-home placement, (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Evans et al., 2003; Gillespie, Burn, & Workman, 1995; Olds et al., 1995). Three interventions involved home visits by nurses (Evans et al., 2003; O’Hara et al., 1998; Olds et al., 1995). Three interventions included the biological parents of the foster children as a part of the intervention (Fisher et al., 2000; Gillespie et al., 1995; Zeanah, Larrieu, Heller, & Scott, 2001).
Home visits were used by many of the intensive interventions which involved 8 of the 18 interventions (Chamberlain & Reid, 1998; Clark & Prange, 1994; Evans et al., 2003; Fisher et al., 2000; Gillespie et al., 1995; Henggeler et al., 1999; O’Hara, 1998; Olds et al., 1995).

Many of the components of the preventive interventions involved education, training, socializing, and support. One study used teacher training (Webster-Stratton, 1998). Enhanced Home-Based Intervention (HBCL+) included a bicultural advocate who established a parent support group and provided individualized parent support and advocacy (Evans et al., 2003). Effectiveness of intervention treatment resulted in all but two interventions reporting significance of treatments effects (Horowitz et al., 2000; Zeanah et al., 2001). In the preventive intervention (Zeanah et al.) outcomes for children in foster care were measured. Results indicated more children were freed for adoption and fewer were returned to their abusive birth families. This preventive intervention led to changes in the permanency plan outcomes made by judicial and child welfare systems. Termination of parental rights increased and the return of children decreased. As a result of children not returning home, maternal maltreatment decreased in the intervention group (Zeanah et al.).

Findings in the Foster Care Clinic (Horowitz et al., 2000) indicated that there were no significant differences between the two groups existing in medical, educational, developmental, or mental health problems identified by foster mothers. However, children in the intervention group were more likely to be identified with developmental (56.5% vs. 8.6%) and mental health problems (37.1% vs. 13.8%) by providers than children in the comparison group. They concluded that community providers identify medical and educational needs of young children entering foster care but fail to recognize their developmental or mental health needs (Horowitz et al., 2000). Parent-Child Interaction Therapy (Borrego, Urquiza, Rasmussen, & Zebell, 1999) revealed promising results with a decrease in externalizing and internalizing disorders, along with parenting stress. Enhanced Home-Based Crisis Intervention (Evans et al., 2003) had a large sample size, effective effect sizes, random assignment to three groups, but no control group. Results indicated significant differences in HBCL+ vs. other treatment groups with a moderate effect size ($d=.43$, $p < .01$) in both FACES II and CBLC. Respite Care (Cowen & Reed, 2002) indicated significant differences in treatment effects and had a large sample size but did not have a control group. Partner’s Intervention (Webster-Stratton, 1998) had a large sample size, random sampling to treatment and control groups and reported significant results in all domains. They
also included treatment protocol in their article along with comprehensive training. Prenatal and Home Visitation by Nurses (Olds et al., 1995) found that participation in early intervention was associated with a 79% reduction in state-verified cases of child abuse and neglect among mothers who were poor and unmarried.

Qualitative studies reviewed appeared to provide valuable information regarding the therapeutic needs of foster children. Robert Pynoos (2002) developed a school based group therapy model designed for foster children. As a result for his six week group therapy intervention foster children were able to process their foster care experience. Results indicated that it took five sessions for the children to tell their foster care story. Overall the group therapy was successful and the leaders and group members had collaborated in creating a therapeutic holding environment (Williams et al., 2002).

Another unique clinical therapy approach is NTU an innovative Therapeutic Foster Care (TFC) program. NTU is particularly applicable for people of color as it is built philosophically, on an Afrocentric worldview that accommodates the perspective, process and learning style of African people. It is applicable across cultures as its strong values orientation reflects the premise that therapists are not neutral and have a responsibility to support strong families and communities in their cultural context. Its attention to this process encourages the client system to define for itself what a strong family and a strong community is. Authors Gregory and Phillips (1997) used this model to treat foster children who are African American. Qualitative results indicated that African American foster children benefited from this approach (Gregory & Phillips, 1997).

In summary, none of the above interventions address foster children who were initially placed in foster care in an effort to prevent problem behaviors from developing. Wraparound services that may provide a surfeit of professionals involved in the care and the welfare of the foster child often failed to include the child’s perspective in the intervention. In fact, a recent study revealed that foster children are often confused about the many professionals that are involved in wraparound services. One foster child complained that mental health professionals were inaccessible and irrelevant to their needs (Blower, Addo, Hodgson, Lamington, & Towlson, 2004). Transitional group therapy was developed in attempt to fill the gaps in current interventions available for foster children.
Treatment

Intervention Development

TGT was developed based on the research and development (R & D) tradition. This approach involves the combining of qualitative and quantitative methods. The overall plan included determining a need, planning a strategy for filling that need, and developing a preliminary model of the strategy (Borg, 1987; Borg & Gall, 1989; Williams, 1991).

TGT was developed based on the *best practice* approach. The *best practices* approaches are those programs that attempt to connect the bridge between research and direct practice. Implementing a “best practice” approach entails developing an intervention that will target multiple levels of treatment and find out what works in a related setting and utilize it with foster children. This may include the individual, family, school support, and community support. According to the National Adolescent Health Information Center (2004), developing a best practice child mental health intervention program may involve the modifying of individual risk factors and protective factors. It may also include treatment that focuses on skill building, empowerment, self-efficacy and individual resilience, and respect. TGT was developed to target risk and protective factors and promote resilience in first placement foster children.

*Evidenced-based* interventions are also used to describe best practices. This includes research studies of literature documenting rigorous evaluation of an intervention and proving its success. Experimental research that has proven positive results and determines generalizability and reliability are most valued. A *promising practice* is defined as study that produced some positives outcomes on qualitative or quantitative results (National Adolescent Health Information Center, 2004).

As a result of the dearth of interventions available for foster children, a preventive intervention was created by this researcher to address gaps in the current literature. Modeling a *best practice* approach, Transitional Group Therapy was developed based on the needs and lack of specific interventions currently available for foster children. This new treatment intervention evolved from this therapist’s clinical experience, informal observations, creativity, and theoretical perspectives. Development of TGT consisted of three stages incorporating the concept of systemically developing techniques, 1. Identifying the consumer and determining needs, 2. Generating ideas for perceived need, and 3. Developing and field testing, and revising (Bischoff, Mckeel, Moon, Sprenkle, in Sprenkle & Moon, 1996). A flowchart has been devised.
to represent the process of the intervention development of TGT. This following model is based on a description of each aspect of resiliency and each session and intervention used in TGT to target promoting characteristics of resiliency (see Appendix I).

**Figure 1. Resiliency and TGT Intervention**

**Description of Transitional Group Therapy**

Transitional Group Therapy is an experiential approach that focuses on play therapy techniques (e.g. sand tray, drawings, puppet play, and role-play) and psychoeducation of
resiliency characteristics. (see Appendix B). Objectives and activities chosen for the group focused on utilizing developmental and resiliency concepts. The short-term goals of TGT included: (a) ease child’s abrupt and often traumatic transition into placement by learning characteristics of resiliency; (b) reverse feelings of loss, abandonment and betrayal by separation from the biological family by encouragement of expression of feelings and emotions; (c) enhance self-control of dysregulated behaviors and emotions by learning anger management and boundary issues; (d) help child develop an inner sense of psychological permanence by increasing self esteem and group identification; and (e) decrease feelings of stigmatization.

Long-term goals included: (a) self-confidence, connection, commitment to others, self worth; (b) future orientation, belonging and group membership; (c) responsibility and self awareness; (d) physical health and mental health; (e) expression and creativity; (f) roles and contribution to service; and (g) emotional, motivational and strategic supports and access to resources (see Appendix A).

A TGT manual was devised with an objective at each group session targeting treatment goals. Also a schedule of activities were utilized that were developmentally appropriate for ages 6 to 12. Utilizing a strength-based approach, this intervention was also designed to prepare, support, and educate children about the foster care experience and allowed for emotional expression in a group setting. This relational group milieu emphasized the individual child within a resiliency-promoting framework. Group sessions consisted of three stages: (a) stage 1 (sessions 1-3) establish rapport, overview of activities and goals; (b) stage 2 (sessions 4-7) introduce resiliency traits (social competence, creativity, self-assurance, support, and expression of feelings and emotions; and , (c) stage 3 (sessions 8-12) integration of knowledge gained by group participation.

Resiliency characteristics were also introduced to foster parents and relative caregivers. An agenda of group activities were provided to caregivers to allow for a continuation of therapy between group sessions. Homework was given to children to take home and addressed at following sessions.

**Description of Facility**

The intervention research took place at Children’s Home Society (CHS), a community-based service provider. Children’s Home Society is a statewide agency that provides a variety of services for children and families. Founded in 1902 as an orphanage in Jacksonville, CHS now
has 14 divisions throughout Florida. The foster children will go through a typical intake process and thus they will be charged for the group therapy service. The facility that has agreed to provide this research is the North Central Division of CHS. The division serves eight counties, operating out of four locations, including an emergency shelter. The play room and group room were readily available with observation mirrors and videotaping capability. The play room was equipped with selected toys and art materials provided by this researcher.

**Description of Training Therapists and Treatment Fidelity**

To monitor and sustain the integrity of the TGT intervention, a manual was devised including detailed outlines and checklists that described the necessary materials for each session, with specifics objectives and activities (see Appendix B).

This researcher is a Licensed Marriage and Family Therapist and a Registered Play Therapist. All group sessions were directed and monitored by this researcher. A one-way mirror was available to observe group sessions and make observations and consultation to trained therapists facilitating the sessions. Each therapist was trained in TGT; including philosophy and purpose, and play therapy. The lead therapist was a PhD intern who was enrolled at Florida State University in the psychology department. He specialized in anger management and coping skills. This researcher provided all the materials for each group session, including snacks, art materials, and play therapy toys. Two bachelor’s level assistants were also utilized, one for each group that served as technicians to videotape all sessions. They were trained in confidentiality and maintaining a secure locked file for videotapes.

**Rationale for Current Study**

Considering the state of the foster care system, preventive and early intervention is an important element that appears to be lacking when foster children initially enter foster care. The literature is sparse about how the harmful effects of foster care may be limited or prevented when children are first placed in foster care. Although it has been well documented that intervening early in placement is essential in treating foster children no interventions were found in the literature for first placement foster children (Clyman, Harden, & Little, 2002; Dozier, Higley, Albus, & Nutter, 2002; Stormont, 2002; Weil, 1998). Foster children may be at great risk for the development of behavioral problems and in need of early therapeutic intervention. It may be valuable to look at children at risk who experience their first out-of-home placement in order to disentangle the effects of their experiences before placement, from what happened while at a
protected environment (Weil). Foster care groups can offer significant primary and secondary prevention benefits (Williams et al., 2002). In reviewing several factors related to what influences change in children, significant discoveries were made during the 90s demonstrating that genes and the environment interact throughout children’s development. The potential application for these findings for early identification and treatment was significant for foster children (Hoagwood & Olin, 2002).

Best practice therapeutic interventions are needed for foster children. A workgroup was established in 1999 on Child and Adolescent Mental Health Development and Deployment (CAMHCW) (National adolescent Health Information, 2004). They reviewed research and training regarding child and adolescent mental health within the past 10 years. They made recommendations for strengthening and accelerating the pace of research on interventions (i.e., treatments, services, and preventive interventions strategies) for children and adolescents. In an effort to gain knowledge from intervention testing and dissemination, research must inform basic research theory and development.

The Contributions of Group Therapeutic Processes

Group therapy may assist foster children in dealing with difficult issues that they may frequently encounter on a daily basis. By sharing their experiences and stories with other children they may come to understand that they are not alone in their plight and so reduce feelings of shame, isolation, and guilt (Dies & Burghardt, 1991).

Social support is also a natural result of group participants. Sweeney (1999) suggests three benefits that may be achieved through use of group play:

1. Group therapy can encourage children to develop a therapeutic relationship with a counselor; assisting withdrawn children may be more likely to engage in play therapy when observing others,
2. Children have the opportunity to develop and practice interpersonal skills in a group setting; through practice and utilizing games and activities—thus transferable to other settings.
3. Group therapy offers children the opportunity to learn vicariously through others; by children witnessing the play, growth, and insight of other children, group play therapy offers children increased opportunities to understand their own behaviors.
The purposes of utilizing a group are to lessen stigmatization and promote group support. As earlier indicated, foster children may be embarrassed and shameful about their family and experiences that have led them to being in foster care. This group may be an attempt to give children the opportunity to understand they are not alone in the experience and elicit support. From a developmental perspective, group counseling is a natural context in which children can work on issues relevant to their age group. Group process for children can also be more productive than individual therapy because it involves peer motivation to change, provides positive adult attention that is nonintrusive, serves to prevent later chronic problem behaviors, and enhances brain functioning, by engaging the right brain through symbolic thinking (Drewes, Carey, & Schaefer, 2001). Preadolescent children are particularly open, receptive, and engaging in group therapy (Drewes et al., 2001). The maturation of the frontal lobe continues in early adolescence and the speed of thought and efficiency increases. Emotional regulation becomes greater, along with planning and problem-solving.

Open and closed groups exist. Closed groups are defined as groups that accept no new members and “shuts the gates” to new members and usually meets for a predetermined number of sessions. Open groups maintain a consistent size by replacing members as they leave the group. (Yalom, 1985). Frequency of some group sessions range from 1 to 5 times weekly. Once weekly meetings are most common, but when group members meet more than one a week, it increases intensity. The frequency of group sessions for closed groups depends on the type of group and purpose of the group. The majority of groups are open groups, but ‘marathon” groups were used in the past for the purpose of self-discipline, intensive interpersonal confrontation, and affective involvement and participation (Yalom, 1985). The group size recommended for children’s groups is between five and ten members (Sweeney, 1999).

For the purpose of this exploratory study, TGT used two closed groups of five and six members that met twice a week for six weeks. TGT was designed with the purpose of addressing issues that children may face in their foster care experience. Objectives were defined and activities and discussions were designed to address issues that foster children may encounter in foster care or out-of-home placement. The groups met twice a week, which made it an intensive intervention.

**Contributions of Play Therapy**
Play is perhaps the most developmentally appropriate and powerful medium for young children. It can be used to develop cause and effect thinking critical to impulse control, process stressful experiences, and learn social skills (Drewes et al., 2001). Children under 12 have difficulty sitting still for sustained periods of time. Play therapy provides for children’s need to be physically active. In play, children discharge energy, prepare for life’s duties, achieve difficult goals, and relieve frustrations. Play also helps children express their imagination, learn trappings of their culture, and develop social skills (Drewes et al.). According to Garry Landreth (2002), well-known play therapist, toys are children’s words, and play is their language. Play is the most natural dynamic and healing process for children to process their experiences (Landreth).

Play therapy was used throughout the 12 sessions. Free play was designated at the beginning of each group session and at the end of each group session. Also play therapy techniques such as sand tray play, puppet play, and art activities was incorporated in the group sessions to address specific objectives in order to promote resiliency.

**The Importance of Content (Psycho-Education)**

Group and play therapies uniquely facilitate desirable aspects of human growth. However, TGT also incorporates the normalization, prediction, and possible prevention of symptom formation attendant upon the normative challenges and crises of foster placement. These critical events systematically inform the TGT sessions and the “curative” processes of group and play therapies concurrently are brought into play in the context of that content. The psycho-educational orientation recognizes that many crises cannot be avoided, and that human beings are not to blame for experiencing them. However, these life events and their human responses can be anticipated and addressed with the goal of good enough adjustment (Conyne, Crowell, & Newmeyer, 2007.)

**Conclusion**

As a result of the review of literature, an intervention was developed by this researcher that may provide first placement foster children the tools to survive their experience. The intervention was developed by researching the foster care experience and current available interventions for foster children. Also resiliency was investigated and several aspects were implemented in a group, play, and psycho-educational therapy intervention. Combining both treatment and prevention, TGT was developed utilizing the Research and Development (R & D) process by identifying the current needs of foster children.
CHAPTER 3

METHOD

In a pilot “R and D” study the questions are very basic (Cameron, C., Herman, S., Keiser, N., Noor, I., Sanders, J., & Seeley, J. (2003). The ultimate question may be “To what extent does this intervention work?” However, the more immediate, fundamental question is “Can it be done?” This is the question of implementation, and the goal is to identify barriers to recruiting of staff and recruits, training of staff, fidelity of intervention, and completion of the intervention (Lee, in press). TGT was evaluated by utilizing both qualitative and quantitative methods. Qualitative methods are encouraged for use during preliminary cycles of research when there is an emphasis on exploration (Yin, 1989 & Corbin & Strauss, 1994). It is understood that the tentative model of the intervention consists of the potential of numerous revisions based on recursive iteration with qualitative and quantitative data. The diverse findings help shape progressive versions of the intervention with an eye toward improved implementation and, ultimately, validity for the population.

Although the first purpose was to design and be able to implement an intervention that addressed the needs of foster children who first enter care, the second purpose was to explore this therapeutic intervention for initial signs of effectiveness. The following represent research questions, hypotheses, definitions, assumptions, and limitations. Also implementation evaluation and recruitment barriers will be identified in foster children, families, agencies and training staff. Finally, the participants, procedures and instrumentation, and data analysis will be reviewed.

Research Questions

1. What are the primary barriers to implementation of TGT with regard to program adoption, recruitment of clients and trainers, training to criteria, treatment fidelity, and completion of the intervention?

2. Does participation in TGT, as currently administered, increase individual resiliency in first placement foster children?
3. Do foster children benefit positively from participation in TGT, as currently administered, as evidenced by statements and actions in group therapy sessions?

4. Does participation in TGT decrease internalizing or externalizing behavior problems in first placement foster children?

**Testable Hypotheses**

1. Children who participate in the current version of TGT will attain a significantly lower mean score on the Child Behavior Checklist (CBCL)-Parent Report after participation in TGT.

2. Children who participate in Transitional Group Therapy will attain significantly higher scores on the Behavior and Emotional Rating Scale (BERS) after participation in TGT.

**Definitions**

For the purposes of this dissertation the following definitions will be used:

*Child.* A male or female between the ages of 6-11

*Foster care.* An arrangement for children who a protective services worker or court has decided cannot live safely at home due to risk of maltreatment

*First placement foster child.* A child who has been removed from their primary caregivers and is placed for the first time in foster care

*Relative placement.* A child who is placed outside his home due to risk factors or extenuating circumstances and placed in a foster home with familiar relatives

*Risk factors.* Factors such as poverty, neglect or abuse, low self-esteem, unavailability of support

*Protective factors.* Contrary to risk factors, developmental assets that protect children from risk factors
Resiliency. The ability to bounce back in the face of adversity

Short-term group therapy. A 6-week intensive closed group therapy

Transitional Group Therapy. A group therapy designed by this researcher to promote resiliency in first placement foster children.

Research Assumptions

This study was shaped – and limited – by the following assumptions:

1. The sample size of first placement foster children available during the time allocated for this study would be adequate to deliver important initial insights about feasibility.

2. The foster parent’s description of the children and their problems would be valid.

3. Foster children will want to participate in group therapy. Although TGT involves fun activities, it is possible that foster children may not enjoy the activities and therefore not participate.

4. Foster families have the time and resources to participate in this study. It is an assumption of this study that attending therapy with their foster children will be manageable by foster parents.

5. Although the TGT intervention was created by a researcher with a passion for this population and its adjustment problems, its findings will be trustworthy.

Theoretical Assumptions

1. Foster children will exhibit individual differences in their response to foster care. Although this will reflect previous circumstances, including circumstances in the custodial environment and those of their removal from it, personal resiliency plays a moderating role.
2. Many foster children are traumatized by being placed in foster care and need treatment to address this circumstance.

3. Although research has indicated that the majority of foster children view foster care as a problematic family disruption, some children may thrive in a different environment than their biological home.

4. Barriers to implementation will exist at all levels in the intervention system: Foster family, child, program personnel, and agency.

Participants

The population of clinical interest was first placement foster children ages 6-12 in the geographical area of Tallahassee, Florida. Times in foster care and reason for removal were recognized as mediating variables and were not a factor in the selection process. Foster children who were placed with relatives were also included in this study. The focus of the desired sample was foster children who were initially entering foster care. The adult participants included the researcher, administrative personnel at the Children’s Home Society, Tallahassee, foster case managers at that agency, and birth and foster parents.

Demographics of Participants

After a list of 28 possible participants was compiled, this researcher began contacting foster families, dependency case managers, and therapists employed at Family Connections, the department of CHS that provides therapeutic services to foster children, to confirm group attendance. After contacting each caregiver or DCM the list was decreased to 19. A computer generated method randomly assigned participants to one of two TGT groups. The number decreased one week prior to treatment due to reluctance to participate. The commitment to six weeks of group therapy was too much considering busy schedules and additional responsibilities. The total number of participants who were committed to TGT treatment was 11 children. Since the number utilized in the computer generated randomization was 19, this researcher assigned two groups, experimental and wait-list. The final two groups consisted of eight boys and three girls. Each group had one sibling group.
All children had experienced either neglect or abandonment. Their ages ranged from 6 to 11. The parents of eight out of the 11 participants were currently incarcerated on various charges; some related and others unrelated to their reason for removal. The majority of the children who participated in TGT had an Axis I mental health diagnosis (American Psychiatric Association, *Diagnostic and Statistics Manual, IV-TR*, 2000); two with an adjustment disorder, five with anxiety disorders; three with attention deficit hyperactivity disorder; and one diagnosed with posttraumatic stress disorder. Seven out of the 11 children were diagnosed with attention deficit, hyperactive disorder, but this was not strictly their primary diagnosis (see Table 1).
### Table. 1

*Demographics of Group Participants*

<table>
<thead>
<tr>
<th>ID#</th>
<th>Age</th>
<th>Gender</th>
<th>Race</th>
<th>Diagnosis</th>
<th>Reason for Removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11</td>
<td>Male</td>
<td>White</td>
<td>314.01</td>
<td>Neglect and abuse</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>Male</td>
<td>White</td>
<td>309.21</td>
<td>Neglect and abandonment</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>Female</td>
<td>White</td>
<td>309.21</td>
<td>Neglect and abandonment</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>Male</td>
<td>Black</td>
<td>309.81</td>
<td>Neglect and abuse</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>Female</td>
<td>White</td>
<td>309.4</td>
<td>MX drugs, neglect</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>Male</td>
<td>White</td>
<td>309.9</td>
<td>MX and FX drugs, neglect</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>Male</td>
<td>Black</td>
<td>300.02</td>
<td>MX drugs, neglect</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>Male</td>
<td>Black</td>
<td>314.01</td>
<td>Neglect and abuse</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>Male</td>
<td>Black</td>
<td>309.4</td>
<td>Neglect and abandonment</td>
</tr>
<tr>
<td>10</td>
<td>8</td>
<td>Female</td>
<td>White</td>
<td>314.01</td>
<td>Neglect and abuse</td>
</tr>
<tr>
<td>11</td>
<td>7</td>
<td>Male</td>
<td>White</td>
<td>300.02</td>
<td>Neglect and abuse</td>
</tr>
</tbody>
</table>

*Note.* 309.9= Adjustment disorder, unspecified, 309.4= Adjustment disorder with mixed disturbance of emotions and conduct, 314.01= Attention deficit hyperactivity disorder, 300.02= Generalized anxiety disorder, 309.81= Posttraumatic stress disorder, 309.21= Separation anxiety disorder (DSM-IV-Revised), FX=father, MX=mother.

### Implementation Evaluation

To uncover barriers to implementation an attempt was made to execute TGT in the foster care department of the community agency designated for their care (Children’s Home Society of Florida, Tallahassee). Four groups were envisioned, meeting twice a week at the agency, for 12 group sessions over two six week periods. Two groups would be experimental groups and two groups control groups with all groups receiving the TGT intervention. There would be structured activities and open discussion that targeted increasing individual resiliency in a relational group.
milieu. In accomplishing this goal, barriers were expected to be met and identified throughout the foster care system, that is, in the foster children, their foster families, the relationship of both to the agency, within the agency, and within the intervention staff.

Using a number of different sources and a variety of methods enhances sensitivity to the data and the credibility of qualitative data (Strauss & Corbin, 1994). Extensive field notes were taken by this researcher during interaction with agency personnel, TGT trainers, possible TGT participants, and foster parents. Progress notes of their sessions were provided by the TGT trainers. Video-tapes were also obtained from all TGT sessions and transcribed by this researcher. These field notes, progress notes, and transcriptions were then open-coded and reviewed for repetitive phrases, which resulted in the emergent of common themes and observations pertinent to the research questions. The field notes provided important descriptors of the context in which statements and observations were made and context was considered the analyses.

Both descriptive and pattern coding techniques (Miles & Huberman, 1994) were used. The coding process started with the implementation research questions, informed by the theoretical assumptions. Broad concepts and initial codes were conceptualized throughout the interview process. Data initially were coded according to broad classes that were directly related to the implementation research question, informed by the theoretical assumptions. Next, the data in each of these classes were examined line by line. Predetermined categories and variables initially guided the coding process. However, additional categories were allowed to emerge throughout the study (Altheide, 1987). The next stage of coding identified patterns contributing to the themes that emerged under each code.

**Outcome Effectiveness of TGT as Implemented**

By utilizing qualitative as well as quantitative methods the study was further evaluated for suggestions of effectiveness. Qualitative data were culled by this researcher by reviewing videotapes of each session, scrutinizing group sessions notes, and examining group participants demographic and bio-psychosocial evaluations. Quantitative material was gathered by administering two instruments to caregiver’s pre and post intervention to measure resiliency
(BERS) and behavior (CBCL). The following description of the methodology includes procedures, instrumentation, and data analysis.

**Procedure**

Each relative caregiver or foster parent signed an informed consent for treatment, which included consent for videotaping and photographs (see Appendix F). Also, biological parent consent was also obtained for each child if relative caregiver was not considered a permanent guardian (see Appendix G). Children were explained the treatment in detail and also signed a child assent form (see Appendix H).

Paperwork completed by caregivers provided them with a description of the TGT intervention and other planned activities during the sessions and the researcher also explained them verbally. Children were pre- and post-tested for the presence of mental health symptoms, on the one hand, and traits of personal resiliency, on the other. The Child’s Behavior Checklist (CBCL), measured behavior and the Behavior and Emotional Rating Scale (BERS) measured personal resiliency. The WLC group received TGT treatment following the initial treatment group.

Groups of (6) and (5) met two times a week for six weeks, which resulted in 12 total sessions per group. All children became active open client cases of Children’s Home Society, Family Connection, which required group therapy treatment plans and additional informed consent of treatment. Each group session was videotaped for the purpose of observation of group therapy activities and discussions. Debriefing interviews were provided following treatment at the final group session.

**Instrumentation**

Pre-testing and post-testing included foster parents completing the Children’s Behavior Checklist (CBLC), and the Behavior and Emotional Rating Scale (BERS). Instruments were carefully selected to measure the variables; internalizing and externalizing behavior (CBCL) and resiliency (BERS). Participants also completed a demographic sheet that provided contact information and family constellation.
Child’s Behavior Checklist

The CBCL is designed for children ages 4 to 18, and is the most commonly used measurement in published studies of child pathology (Vignoe & Achenbach, 1998). It contains 118 behavioral items. The results of the questionnaire give a profile composed of nine problem scales (withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, aggressive behavior, and sex problems (Kroes, Kalff & Steyart, 2002). It provides a parent report of a child’s behavior across multiple domains. The CBCL has been well standardized and has excellent reliability (test-retest correlation = 0.93, interparent correlation = 0.76, Cronbach a = .96 (Wamboldt, Wamboldt, & Gavin, 2001).

Behavior and Emotional Rating Scale

The BERS is a strength-based assessment which measures emotional and behavioral skills, competencies, and characteristics that: (a) create a sense of personal accomplishment; (b) contribute to satisfying relationships with family members, peers, and adults; (c) enhance one’s own ability to deal with stress and adversity; and (d) promotes one’s own personal, social, and academic development (Epstein & Sharma, 1998).

The Behavior and Emotional Rating Scale was empirically developed from parents’ and mental health, social service, and educational professionals descriptions of youth behaviors and emotions that demonstrate strengths by employing a Delphi methodology (Epstein & Sharma, 1998). It is a 52-item rating scale for youth ages 5 to 18 years (Epstein & Sharma). The items involve five standard subscales: interpersonal strengths, affective strength, family involvement, school functioning, and intrapersonal strengths. A likert scale ranging from 0-3 measures the overall strength calculated by summing across the five standard subscales. Alpha coefficients for the five BERS factors are strong, ranging from .91 (school functioning) to .98 (interpersonal strengths). Measuring social resources and youths strengths suggests that resilience or protective factors predict outcomes better than deficit or risk factors alone (Garmezy, 1997).
Data Analysis

Data analysis consisted of both qualitative and quantitative methods. Data was collected and stored in a designated locked file and analyzed at the completion of the study by this researcher.

Qualitative Analysis

All sources of data were compiled: video tapes of TGT sessions, progress notes, and participant case files (compiling illustrative case histories). Video-tapes were viewed and analyzed by this researcher by the utilization of an informal constant comparison method. This process revealed emerging patterns and themes (Maykut & Morehouse, 1994). Materials were analyzed for meaning, looking for reoccurring words, phrases, and topics. Also significant statements and reactions related to group activities were also noted in transcription. A summary of group sessions revealed repetitive themes divulging commonalities among foster children. In additions to thematic subjects, case studies were also included in a mixed method approach including both a quantitative and qualitative data analysis (see Appendix K). An informal case study offers an approach for clinicians who wish to systemically examine their own clinical innovations and present them to other clinicians and is discovery oriented (Biscoff, McKeel, Moon, & Sprinkle, in Sprinkle & Moon, 1996).

Quantitative Analysis

The data collected was analyzed by using a nonparametric test due to the small sample size of participants as well as possible violations of parametric test assumptions. The Child Behavior Checklist (CBCL) and the Behavior and Emotional Rating Scale (BERS) were analyzed by utilizing a correlated group design wherein the same subject is measured twice and to test the two-tailed hypothesis that there will be a difference between pre intervention and post intervention scores.

Approval to utilize human subjects from the Florida State University Institutional Review Board was obtained for the purpose of this research (see Appendix D). Approval was also obtained from the Institutional Review Board of the Florida Department of Health (see Appendix
E). The potential risks for the children participating in this study were considered minimal. Moreover, the participants were given the opportunity to continue individual or family therapy at the Children’s Home Society after the completion of TGT.
CHAPTER 4

RESULTS

The research questions address two issues: Part I, barriers to the implementation of TGT, that is, its feasibility, and PART II, the potential therapeutic effectiveness of TGT. Answers to the first issue, barriers to implementation, largely come from my detailed field notes as this researcher attempted to initiate and administer TGT. The second issue, the potential for this intervention’s effectiveness, was explored through the review of field notes, progress notes by the TGT lead therapist, the video transcripts of TGT sessions, and the pre- and post measurements administered to the foster parents or relatives of group members. Three case studies also were complied (see Appendix K). The narratives provided context and may suggest what aspects of TGT might have the most potential relative to client attributes and needs.

Part I: Feasibility of TGT

The field notes were reviewed separately for each implementation issue: Recruiting the involvement of the agency, recruitment of group participants, recruitment of trainers, training issues, fidelity of treatment, and intervention completion. Within these separate searches, this researcher used systemic lenses to uncover inhibiting and facilitating factors in the individuals involved, and then in the larger systems, in which they were embedded, (e.g., foster family, agency, foster care system, and community). Included in this outline are lessons learned as a result of this evaluation.

Getting an Agency Involved

Barriers and Facilitators to Agency Recruitment

In Florida, the foster care system is overseen by the Florida Department of Children and Families (DCF), whose employees sometimes provide services, but who otherwise contracts with local child-serving agencies. In Tallahassee, its primary contractor for foster care services is the Children’s Home Society of Florida, by whom this researcher was employed as a child-therapist. Therefore, This researcher went to the Children’s Home Society, housed within the
Department of Children and Families at 3019 Jackson Bluff Road, which is its primary office in Tallahassee. The Children’s Home Society’s agency supervisor arranged a meeting with the supervisors of dependency case managers. Goals and procedures of TGT were explained and how participating in the research could benefit foster children and their caregivers. Supervisory personnel were given referral forms to distribute to their case managers and enrollment instructions. Concurrently, an email explaining the research and the intervention was sent to all the DCF dependency case managers in the eight counties surrounding Florida State University. This initial attempt to gain the involvement of the CHS failed. The field notes indicated the following barriers:

- Agency supervisors appeared to have too few administrative employees to inaugurate additional programs, and their dependency case managers were preoccupied with over-sized case loads.
- Attempts to help the CHS personnel by contacting families for them was frustrated because the dependency case workers said that they were too busy to provide the necessary efforts to formally enroll recruited families.
- Many dependency case workers were initially interested. However, they were unable to follow through. It appeared that they did not have the time to invest in making referrals not mandated by Family Court.
- There was rapid turnover of case managers. Promising contacts were replaced by new personnel, who had no knowledge of TGT.
- Most dependency case workers used private providers for counseling for foster children.

This researcher then turned to other agencies expected to yield recruits, especially those under contract to the DCF to provide foster care services. Flyers were distributed, emails were sent, and personal visits were made to Family Connection, Camelot Foster Care Program, and the Center for Marriage and Family Therapy at Florida State University. Even though over 200 foster children are estimated to reside in the 8-county region, no referrals were obtained. The following barriers were identified:

- Communication problems within agencies existed between departments within the organizations.
• Agencies did not tell their constituent families about possible interventions available elsewhere.

• Agencies were reluctant to get involved in research that appeared to have no direct benefit to them providing their services.

• Agency personnel appeared to lack interest in participation in a new intervention such as TGT. They continued to rely on current service providers to provide traditional counseling services.

• Personnel were spread thin by their existing responsibilities, and lacked the time and energy for new involvements.

**Lessons Learned with Regard to Agency Recruitment**

This initial study taught the following regarding TGT being made available to foster children through agencies that currently serve them:

• Agencies may lack enthusiasm for unknown and unproven interventions.

• Agencies are unlikely to volunteer to add such interventions onto services they already provide. Personnel generally feel burdened by current obligations. Successful approaches may involve demonstrating how TGT may help them meet these obligations.

• The privatization of child welfare agencies may have created competition between local service providers. Several agencies were now involved in foster care treatment and services. Individual appeals, tailored to the agenda of each agency, may need to be made.

• Family Court determines what services foster children receive, and group therapy was not an option for foster children. Child-serving agencies defer to Officers of the Family Court. Therefore, the Family Court needs to be made enthusiastic about new interventions.

This researcher thought that TGT would be appealing because it was a viable option for the agencies’ constituents to adapt, and it TGT also seemed likely to ameliorate the daily behavioral crises about which case managers complained. Personal capital was beginning to appear to be the most obvious facilitating aspect. If referrals for therapeutic services were to be made, it was to providers who had built relationships with the agency and its personnel. Despite
efforts to inform child welfare workers and other agencies about the benefits of TGT, alliances appeared to exist among case workers and local service providers. TGT may have been viewed as competitive or incompatible with that which was currently offered by community providers. In fact, TGT would finally be implemented through the Children’s Home Society, but at an address separate from the division responsible for foster care. This researcher was employed as a part-time therapist for the Children’s Home Society of Florida (CHS) at its cross-town Family Connection site. As a result, this became the research site. Moreover, being employed there, the researcher knew the lead therapists and assistants personally and therefore was able to recruit them for this study.

**Recruiting Group Members**

The children who participated in this pilot study of TGT were recruited from child therapists at CHS where this researcher was employed. Although this preventive intervention was potentially available to hundreds of foster children, eligible children could not be identified, recruited, and enrolled because – as noted above – the agencies responsible for them could not be effectively engaged. Given the importance of a working alliance (Bordin, 1994) the foster parents and the foster children had to be made aware of the program, and in agreement with its goals and technique.

**Barriers To and Facilitators of Group Member Recruitment**

Because institutional personnel were discovered to be the gatekeepers to TGT, threshold conditions only occurred at CHS where this researcher had access both to administrative authorities and foster care supervisors and case workers. The primary facilitating conditions were my relationships with the various personnel, leverage provided by the agency director and the supervisors of the case managers, and my ability to communicate with and “sell” TGT to the latter. Another facilitating factor was the credibility of TGT as a tool with promise to remedy concerns that the agency personnel had about the children under their care. Nevertheless, even though the agency personnel had been recruited, there were barriers in recruiting foster children and their families.
Although the foster children and their foster parents expressed various degrees of enthusiasm for TGT, many were too busy to get involved in any activity that would increase the families’ duties. Just getting their children to TGT sessions -- twice weekly, for 6 weeks -- impressed many foster families as too large of a commitment.

Some foster parents were already feeling overwhelmed.

Some foster parents did not believe that participation in TGT would provide any short-term or long-term benefits for their foster child or for the family. This lack of understanding of the possible benefits of their child’s participation was considered a barrier to recruitment and subsequently an obstacle to implementation.

Some children who may have wanted to participate in TGT were unaware that group therapy existed as an option and therefore did not participate because they were not given a choice.

**Lessons Learned about Recruitment of Foster Children for TGT**

- The program being accepted by some staff and referrals being made may not be enough. In fact, it was found necessary to visit foster families at home to provide detailed information about TGT and to complete the initial documentation package, namely, obtaining informed consent from the adults and assent from the children, and then administering the demographic survey and the pre-TGT assessment instruments.

- It was also found necessary to approach the children after caregivers approved of their participation. Each child was explained the Child Assent in detail, the activities they may participate in and the option to stop their participation at anytime without repercussions.

- It may be necessary to involve the family court system in order to give the foster child an opportunity to participate in new interventions to initially assist them in their transitions into foster care.

**Recruiting TGT Staff**

Since the research took place at Children’s Home Society, Family Connection Program where this researcher was employed as a therapist, qualified therapists were available with the assistance of the program director of Family Connections. It was ultimately her decision who
would lead the groups. Family Connection accepted interns from the Psychology Department at Florida State University and the chosen therapist to lead the groups was obtaining his PHD, had voiced an interest in forming anger management groups at CHS.

Typically child-therapists need a minimum of one year experience with children in order to work with children at CHS. Therapists are supervised by the program director and carry a case load of children who receive outpatient counseling. Therapists are not required to be licensed in their mental health field and they work under the licensure of the program director, who signs off on all therapists’ paperwork. The lead therapist expressed interest in leading the groups and was open to training in TGT and play therapy.

Two assistants volunteered their assistance in groups and taped sessions and organized files. Both assistants had bachelor degrees and were employed as Targeted Case Managers at Children’s Home Society. Both assistants had a personal interest in participating in research to gain additional experience in working with children. They administered snacks, video-taped sessions, and helped with art projects, and helped with the organization of paperwork and tapes.

**Lessons Learned about Recruiting Program Staff.**

- Once a program is accepted by an agency, personnel will be provided.
- The qualifications of the personnel for the specific program will be limited by the agency’s human resources.

**Barriers to Implementation of TGT**

The majority of the group participants had been diagnosed with attention deficit hyperactivity disorder (ADHD), although it may not have been their primary diagnosis. Many took medications to control their symptoms. Although some may had been prescribed medication, it appeared to be less effective in the late afternoon when the groups started. Many of the children had difficulty following directions and sitting still in several group activities. After viewing video-tapes, it was observed that the lead therapist had to redirect children displaying behavior problems during sessions numerous times for a one hour group session. The therapist also utilized the children’s need for redirection as a teaching tool on behavior. Although
it was expected that some children would have a mental health diagnosis, problems with following rules, impulsivity, and hyperactivity was not anticipated and interfered with the implementation of TGT.

**Lessons Learned with Regard to Barriers of Implementation**

- Thoroughly assess children at the onset for problems with inattention, impulsivity, and hyperactivity and any other mental health diagnosis that may interfere with the structure and operation of group sessions (e.g. medication, behavior strategies currently utilized, etc.)
- Be prepared for methods of handling the breaking of group rules and methods of discipline to be utilized in groups (e.g. notifying caregivers, time-out, etc.)

**Training Program Staff**

For TGT to be refined, tested, and extended it, processes had to be manualized, that is, put into a written form (a manual of instructions) so that it could be replicated on future dates, perhaps at other sites by other personnel. The manual included a description of each group session numbered 1-12. Each group session was governed by an objective, an outline of activities, and specifications of materials to be used. The TGT staff participated in a three-hour training centered on the manual and its detailed explanation of each session’s objective, and attendant activity – often therapeutic play. The TGT assistants also were trained in confidentiality. The brevity of the training facilitated its acceptance. Nevertheless, there were barriers. These barriers were as follows:

- Training time competed with other staff obligations.
- The therapist was only interested in training specifically in TGT; the therapist was not interested in more contextual training, that is, training in play therapy and group process.
Lessons Learned with Regard to Staff Training

Brevity of training may be desired by program staff. However, this desire competes with the need to ensure that they are able to address the hundreds of interactions likely to occur in group sessions. Consequently, revisions in the future would include:

- Provision of incentives for participating in the research
- Recruitment of therapists who have a interest in working with foster children and their families
- Recruitment of therapists who have an interest and prior experience in play therapy
- Additional training as needed after the groups begin (e.g. limit setting in group therapy, art therapy, play therapy, etc.)

Treatment Fidelity

In order to assess the extent to which each therapist correctly implemented TGT as manualized, each session was video-taped as well as viewed through a one-way mirror. This therapist used checklists to audit adherence to TGT goals and objectives. Treatment fidelity was an issue that included extensive planning prior to the beginning of groups to assure adherence to the goals of TGT. The role of the lead group therapist was instrumental to assure the deliverance of TGT. Accordingly; this researcher found that the TGT facilitator generally adhered to what was required of him. However, field notes indicated that structured activities were interrupted because of the breaking of group rules by the foster children, and a lack of specifics of play therapy approaches. Inexperience of the facilitator with play therapy techniques (e.g. tracking methods, nonevaluative observation, and limit setting) resulted in episodes of having to spend a significant amount of time disciplining group members. In addition, important therapeutic experiences such as sand tray play and puppet play were left unprocessed within the group session.

Barriers to Treatment Fidelity Included:

- Lack of experience in play and group therapy by the TGT therapist
- Lack of interest in acquisition of experience in play and group therapy by the therapist
• Narrowness and brevity of initial TGT training
• Lack of ongoing training

Lessons Learned with Regard to Treatment Fidelity

• The auditing procedures were adequate and necessary
• The recruitment and training requirements listed above must be addressed

Completion of TGT and Mortality

All participating group members completed TGT and obtained certificates of completion (see Appendix J). One group member was excluded from the final quantitative results because his caregiver did not return the final CBCL and BERS instruments. This researcher viewed the fact that there were no dropouts in treatment as a possible affirmation of TGT from the families and children who participated in it. Documented observations confirmed that the children had formed solidarity with other group members and no doubt this may have contributed to their attendance throughout the program. Another facilitating factor may have been fully informed consent by the foster parents and assent by the foster children. Finally, the ambience of the setting was inviting. The lead therapist, although not adequately trained in play therapy, exemplified a caring and compassionate demeanor. Field notes indicated that the overall climate could be characterized by enthusiasm, optimism, caring, and emotional safety.

Conclusion

When you situate TGT within its ecosystemic context (Bronfenbrenner, 2005), you obtain a fuller understanding its feasibility, that is, both of the barriers to, and circumstances facilitative of, implementation. (see Imber-Black, 1988.) There is a systemic reciprocity of those involved in the overall process. For example, this researcher’s social capital with the CHS appears to be based on individual traits, employment, and history with the agency. However, any leverage this researcher has is granted by the members of the CHS. For TGT to be accepted and facilitated by an agency, two things are necessary: Shared goals and enough of a relationship to support work on those goals. Because this therapist had such a working alliance, the CHS provided space, therapists, assistants, and foster children. However, resources provided by this alliance were limited by the nature of its constituent members. For example, the lead therapist
was chosen by agency administrators from agency personnel. No agency employee was as fully equipped to inaugurate TFT as this researcher desired. Similarly, the counseling department of the agency could provide TGT group members. However, the children from which they could make referrals had one or more mental health diagnoses.

Nevertheless, the pilot study indicates that a working alliance with an agency and its constituents is possible for TGT, but that future efforts must address the “lessons learned” about implementation thus far.

**Part II: Investigation of Therapeutic Potential of TGT**

In Part II, this researcher reviews the pilot study to see if there is evidence that it may have the potential to produce the change desired. Of course in the recognition of the limitations of the pilot study described in Part I, combined with methodological considerations (e.g., the representativeness of the sample, personnel, and setting), means that any result cannot be stated with true conviction. The topic is the extent to which there is any suggestion that TGT, once refined and properly tested for efficacy, may reach the goal of being a promising intervention for foster children.

**Treatment Outcome**

**Qualitative Results**

Qualitative results consisted of the compilation by this researcher of information from various methods of data gathering. Field notes involving observations of group sessions were scrutinized along with video-tapes of all group sessions. These provided summaries of each group session as well as emerging repetitive, common themes.

**Group Sessions Summary**

Group sessions were facilitated by a lead therapist and a technician. Sessions were 90 minutes in length and consisted of planned structured activities (see Appendix B). Each session had an objective, activity, and homework. During the first and last session, foster families and relative caregivers participated in a large group session. The final session consisted of a ceremony and a certificate stating completion of the TGT. At the beginning and at the end of each session, free play time was permitted. Homework was also assigned at the end of sessions.
Homework was related to next week’s activities such as, “What do you want to be when you grow up?” Group rules were established early in group sessions to establish order and structure. Snacks were provided at the beginning of sessions to build cohesion and to facilitate informal conversation with therapist and other children. Sessions were conducted on Tuesdays and Thursday, for six weeks, from 4-5:30 pm.

Groups were attended every week by all but one participant. With the permission of the clinical director of the counseling program, this researcher transported one child to group sessions so he could participate in the group because no transportation was available for this particular child. One hundred percent of the group members completed TGT and earned a certificate of completion. Group sessions consisted of three stages; Stage 1 (sessions 1-3) establish rapport, overview of activities and goals; Stage 2 (sessions 4-7) introduce resiliency traits (social competence, creativity, self-assurance, support, and expression of feelings and emotions; and Stage 3 (sessions 8-12) integration of knowledge gained by group participation.

**Stage 1- Establishing rapport (Sessions 1-3).** The first three sessions were instrumental in building rapport and introducing the group process. It was important to build a foundation of what would occur over the course of the next several weeks. In the designing of TGT, the focus was dual: (a) to include activities and discussion that was developmentally appropriate, and (b) to promote and build resiliency traits. The first group session was combined with family members and foster families. It took place in a large conference room and refreshments were provided. The first session with the family consisted of creating a genogram and sharing it with other group participants. Children were introduced to the group facilitator and the group room. Group participants appeared to enjoy the family involvement and the genogram activity. Group cohesion began at the initial meeting when children learned that other children were not living with their parents and their situations were similar.

The second session focused on getting acquainted with one another. Group members introduced themselves and talked about their school. Group rules were established by the children. Both groups decided on the same rules: 1. no running, 2. one person speak at a time, 3. keep hands and feet to yourself, 4. respect others, and 5. use inside voice. Folders were decorated to keep handouts and pictures. Homework was to prepare children for the next session. They were asked to try and remember at least one group member’s name. Group members had a
difficult time deciding one aspect they wanted to share about themselves. Some answers included: “I am good at inventing and fixing things,” “I am good at singing,” “I am good at eating,” and “I am good at drawing cars.”

The third session consisted of discussing characteristics that makes us stronger and prepare us for the future. Super heroes were discussed and group members decorated super hero capes. Various art materials were used to decorate the capes. The idea was to create a cape that represents desired strengths and powers. Children were able to identify with this activity and enjoyed talking about super powers. Some powers identified were (a) invisibility, (b) flying, (c) speed, (d) chakra power, and (e) controlling the wind. Donald had a hard time recognizing a specific power and stated, “I am a hero because I’m a bad guy.” A discussion pursued about what a hero is using examples such as a policeman, fireman, and scuba divers. Mark stated, “The Hulk has super strength and guns can’t hurt him.”

The safety hand activity was also conducted and group members continued to build camaraderie. The safety hand is an activity used to help children identify important personal contacts if they ever feel unsafe (Hobday & Ollier, 1999). The child draws a silhouette of their hand and they think of five people they can call on if they feel unsafe or need to talk. They write those person’s contact names or phone numbers on the fingers of the outline of their hand. Several group members stated that they would call on their friends in the group for support if needed. Many had a difficult time with this activity and needed help identifying those they could contact when in need.

Stage 2- Introducing resiliency (Sessions 4-7). Session four began with the process of introducing resiliency traits such as social competence, creativity, self-assurance, support, and expression of feelings and emotions. Planned activities included discussion of anger and impulsive behavior. Group members were asked to draw a good day and then draw a bad day. Calming music was played throughout this session. Shy group members began interacting at this point in the group process. Bad days were reported as experiencing pets dying, bad guy trying to get me, and someone makes me angry, and good days were finding buried treasure, getting a new puppy, and going to the park. This group session gave group members the opportunity to discuss their problems handling anger. Zy stated that he doesn’t get angry, he gets frustrated. When someone asks him to do something he doesn’t want to do he goes in to his room and screams into
a pillow. Healthy ways of expressing anger was discussed.

Session five consisted of recognizing strengths and talents. Activities consisted of making a puppet that represented themselves. Group members utilized art materials and conducted a puppet show at the end of sessions. As mentioned previously, group members had a difficult time recognizing strengths and talents. Session six focused on problem-solving. Scenarios were read to class and group participants picked the correct scenario such as: What do you do if your friend broke a promise? Correct answers were talk to him/her and explain how you feel. One group member stated that you could kick him in the face. One girl stated that her problem was that her mother needed a house and a job. Problem-solving discussion led into a discussion on being selfish and worrying.

Session seven consisted of a discussion about group participant’s families and roles. Group participants were asked to create a sand tray depicting their families. All the children were able to follow directions and create a sand tray quietly. It appeared to be a very powerful activity and the majority of the children chose not to tell their story. The sand tray needed to be processed after creating this activity. All trays were constructed differently and had different themes.

Stage 3- Integration of knowledge (Sessions 8-12). The last four sessions centered on the integration of knowledge gained by group participation. Session eight consisted of a focus on their future. The question was “what is it you want to be when you grow up?” Each child was asked about their wishes for the future. Results indicated that many children wanted to be in a “helping profession” such as nurse, teacher, army, and policeman. The group activity was to make a mask to depict what they wanted to be. Materials utilized were various arts and crafts such as glitter, feathers, paint, and beads. Each child was asked to share their mask with others in the group if they desire. A book on being selfish was read to the children and selfishness was discussed.

Session nine focused on promoting teamwork, sharing, and taking care of our health by making good choices. Discussion on physical health included exercise, eating, sleeping, and dental care. A book was read to the children concerning all of these elements of self-care. The snack consisted of a vegetable plate along with juice and fruit. Also friendship was discussed regarding why someone is their best friend and how to make friends. Many group members
chose others in the group as their best friends.

Session ten focused on establishing appropriate boundaries, trust in others, social skills, and group cohesiveness. Discussions ensued about what trust is. Children responded, “Trust is having friends” or “Trust is when you forgive someone.” The lead therapist asked the children to name one person they trusted. One child stated that he trusts the world. Another child stated he trusted his mom and dad. Others stated they trusted other children in the group. The activity consisted of providing hula hoops to represent personal space. Personal space was explained as well as the concepts of inappropriate touch and creating a personal bubble. Discussion was about how to handle others that may violate one’s personal space were also reviewed. A blindfold exercise was also utilized in this session. Group members were asked to guide another group member around the office blindfolded to help elicit trust.

By session ten, group cohesion was solidified and sessions were more focused and organized. The objective of group session ten was to express creativity and promote group cohesion. Children were unable to perform the group objective of creating a poem, but a self portrait was completed by the majority of the group members by creating a large silhouette on poster paper. The children were then asked to draw in features and explain their pictures.

The final session completed the TGT intervention. The goal of this session was to debrief children and caregivers on former sessions, meet with caregivers and discuss any reactions or concerns about past weeks of group sessions. Music and food were provided and a diploma was given to each group member for their completion. In addition to the certificate a gold medal, wishing wand, smarty candy, and a glow in the dark star were included in a gift bag given to each group member. Also gifts were given to the lead therapist and assistants. By the end of the last session group members shared phone numbers and said good bye to each other while playing and interacting in the last session. It was evident from the group interaction that it was a difficult time for the children to endure the end of group sessions.

Themes of Group Sessions

After careful analyses of data from field notes and viewing video tapes, repetitive themes emerged in group sessions that merit categorization and reporting. Utilizing the constant comparison method (Maykut & Morehouse, 1994), repetitive words, phrases, and distinctive interactions were coded. Those themes that emerged were as follows: (a) group Camaraderie, (b)
dealing with uncomfortable emotions (c) insecurities and lack of empowerment related to self, home, and others, and (d) the importance of free time and play in group therapy.

**Group Camaraderie**

A common theme in TGT was that children who participated in group sessions were able to identify with other children in the group. In the first group session family members were included and a genogram was completed and shared with other group members. The verbalizations of the participants indicated that they all were aware that they were not living with their parents. The children were able to build group cohesion early in sessions and appeared to bond with one another. Identification with other group members appeared to decrease embarrassment and promoted camaraderie. Group participants developed friendships and a genuine concern and trust with other group members indicated by conversations such as:

- Kim to Guy: “Why weren’t you here last week?”
- Chuck to David: “You are my best friend.”
- Kim to others in group: “Listen to Amy, she can make a duck sound!”
- Kim to Mark: “How come you live with your grandma?”
- Mark to Kim: “So I don’t have to live in that home—it feels good to be adopted. I have a family, dog, and friends.”
- Gary to Jake: “How come you live with your grandma?”
- Jake to group members: “My mom didn’t have a job, but now I go to the park, have good food, and have clean sheets on my bed.”
- TJ to Chuck: “Bye, I love you.”
- TJ about Haley: “She has pretty hair.”
An illustration of the bond that developed between group members was in session ten. One of the assigned activities was *who is your best friend?* Children stated that other group members were their best friends. Also after a discussion on “who to trust and who not to trust” children named other group members who they trusted the most. When group members were late or absent, statements were made by many group members inquiring why they weren’t at that particular session. Groups in the most part were attended by all participants with the exception of a few missed sessions.

Another example of group camaraderie was exemplified in a group activity in session five titled the “safety hand.” The safety hand (Hobday & Ollier, 1999) is used to help children remember whom they should contact if they ever feel unsafe. The child draws a silhouette of hand and they think of five people they can call on if anything terrible happens to them. They write their names or phone numbers on the fingers of the outline of their hand. As a result of this activity, group members included each other in the safety hand. Phone numbers were exchanged at the last group session and friendships were formed and group camaraderie appeared to be the thread.

**Dealing with Uncomfortable Emotions**

As indicated in the literature review, it is well documented that foster children display numerous behavior problems and other problems as a result of experiences prior to placement or following their removal from primary caregivers. In stage 2, which involved introducing resiliency, a reoccurring theme of TGT emerged when it was evident that foster children have a difficult time dealing with uncomfortable emotions. It also occurred during free play and in-between structured activities. Many discussions displayed children’s difficulty when dealing with anger, and problems-solving. In many activities where group members were encouraged to talk about their mask, puppet, cape, sand tray, or other art work, many children stated “I don’t want to talk about it!” Respecting children’s desire for concealing their feelings was honored in group sessions; nevertheless, it also revealed their reluctance to talk about uncomfortable feelings.

**Anger.** Group members shared what they do when they get angry such as run away, go to their room and cry, and screaming in a pillow. Some group members are unsure of what to do when they get angry. Outgoing group member’s comments regarding these emotions appeared to
help others in the group understand how they dealt with them and also contributed to group camaraderie.

Donald: “I get angry a lot!” “I get out of control when people tease me and tell me I’m stupid.”

Zy: “I don’t get angry I get frustrated when someone tells me to do something I don’t want to do. I go to my room, lie in my bed and scream into a pillow.”

Donald: “It’s okay to feel anger but not hurt anyone.” “Anger means you get nervous in your head but not hurt anyone.”

Therapist: “Perfect”

Haley: “Maybe you’re mad at somebody.”

Donald: “Angry in your head.”

Therapist: “Zy had a good thing to do when he gets angry, scream in to a pillow.”

Donald: “Is that what you always do?” “Does it work?”

Haley: “Well you can’t punch the wall…just your pillow!”

In another discussion on anger, children spoke openly on trying to understand what anger is:

Donald: “What is anger anyways?”

Zy: “It is a type of feeling that everybody has.” “It means if you get mad at somebody else, all your feelings go out on that person-like it goes out on your friend.”

Haley: “Anger can lead to fighting.”

Donald: “Uncontrolled anger is when you have anger in your body and you let it out on someone else and then he starts to punch and kick you…and if he is carrying a gun he shoots you.”
Therapist: “So anger sometimes leads to fighting—it that what you mean?”

Donald: “Anger sometimes leads to fighting but taking out a gun and shooting another person.”

Zy: “That’s bad—that’s worse than anger…that’s like.”

Donald: “You go to jail for the rest of your life.”

Haley looks at rules chart: “All feelings are okay but not all behaviors are okay.”

**Problem-Solving.** In session six problem-solving was discussed with children and scenarios were presented to solve. The therapist would present a problem and each group member would chose to answer the way to solve that particular problem.

Therapist: “What is a problem?”

Kim: “My mom and dad need a home.”

Therapist: “I understand that is a problem, but what about a problem that you can fix.”

Therapist: “What makes a problem?”

Mark: “Someone tries to fight me and I have them in a headlock.”

Therapist: “How do you stop the problems?”

Mark: “By doing something good.”

Therapist: “How do we stop worrying about a problem?”

Donald: “Be brave.”

Mark: “Don’t be afraid.”

Kim: “Believe in yourself!”
Therapist: “Say you are standing at the drinking fountain and someone moves in front of you without asking.”

Mark: “I would turn them into a bug and squash them.”

Therapist to group: “Is that a good solution or a bad solution?”

Mark: “Bad for them, good for me.”

In group two problem-solving also was challenging to group members. Again scenarios were presented that yielded the same results. In a revealing dialogue with Donald he discussed the way he deals with problems.

Donald: “I like forget about the problem. If you lose a problem and it tries to come back…you just grab it and throw it over your shoulder.”

Therapist: “So you forget about it?”

Donald: “Yah, like this (gesturing with his hand) what’s this—and I throw it over my shoulder and let it go.

Therapist: “So you forget about it, so does it feel alright if you did that?”

Donald: “I feel fine.”

**Insecurities and Lack of Empowerment Relating to Self, Home, and Others**

Participants appeared to lack empowerment and struggled with activities that focused on recognizing their own strengths and identifying future goals. Children didn’t understand and had a difficult time processing activities such as trying to find something special about them or talking about the future.

Insecurities were revealed by group members by bragging and boasting about possible untruth events or talents. Many children who are placed in foster care feel that they have been removed due to a wrong doing on their part. The result is guilt and feelings of stigmatization, loss, and powerlessness. This can lead to children being overly demanding or overly compliant in
relationships with adults (Williams, et al., 2002). In the pretest of the CBCL nine out of the 11 children were reported by their caregivers to lie. This theme also emerged during the group activities and children told stories about themselves and their experiences that may have not been true. Eight out of eleven were reported to “brag or boast” as indicated on the CBCL. This behavior of boasting and telling stories contributed to the disruption in group sessions. Children talked out of turn and competed for the attention and approval of others in the group. Dialogue ranged from bragging about how many chores they performed to being able to draw airplanes.

Many of the children may be experiencing low self esteem and made self defacing statements during sessions in conversations and interacting with others during group activities. Statements included: (a) “I’m such a fool,” (b) “My ears are ugly,” (c) “I look like a mutant,” (d) “I’m ugly,” (e) “I’ve got a big mouth,” (f) “Who wants to get hit in the head,” (g) “I’m a stupid goose,” (h) “I’m stupid,” (i) “Can I kill myself,” (j) “I’m a bad guy,” and (k) “I’m selfish.” This was also expressed in their self portraits. Several children were very expressive when completing their self portraits.

Kim drew a self portrait and she stated that someone is smacking her in the picture (see figure 2). She added that someone was mean to her at school. She laughed at herself and stated “I have a big mouth.” Kim made statements over a six week period that may indicate insecurities such as: “Stop looking at me,” “Everyone is looking at me,” “Am I bleeding on my tooth,” “My eyes are watering, why is everyone looking at me,” “I want my mommy because I have the hiccups,” “almost everyone is staring at me,” “I need a band aid,” and “Ouch!”
Other statements by group members were made that showed insecurities about self and home such as: “I don’t want to draw my family,” “Mom had to make money,” “mom is in jail,” “my picture looks bad,” “my mom and dad need a home,” I have two things to protect me, my two dogs,” and “I don’t want to tell the story about my family.”

Some children chose to talk about their families they were separated from. Only five out of the eleven children chose to speak about their primary caregivers. Insecurities about their primary caregivers also surfaced in this conversation:

Kim: “I want to be a nurse, my grandmother is a nurse. I want to be a nurse but if my mom wants me to change it-I will be whatever she wants me to be-because she doesn’t have a job and when she does I will change it-I want to be just like my mom.”

Kim (continues about her family): “My mom was a cheerleader and when we get a house…we have a judge and when you guys talk to the judge-well the judge says when my mom gets a job and a house…we can go home with her, she is finding a house for us right now.”

Mark: “I am real good at drawing cars, my dad is real good, I’ll bring a picture of a car that he made, if my grandma will let me.”
Amy: “My mom is in jail, but I love my “me maw” and daddy, I love them in my heart.”

Chuck: “My dad mops the floor.”

Haley: “My dad used to live with me.”

Donald- Haley’s sibling: “We still have our daddy.”

Haley: “I know he used to live with us.”

**The Importance of Free Time and Play in Group Therapy**

Free play was the most enjoyed activity in the group. Group members were able to process their experiences through play before and after group sessions. Children were allowed to participate in *free play* before and after group sessions. This activity involved playing together with play therapy toys in the play room. Although it was a not a structured play therapy session, this time was enlightening while viewing video tapes. It was not the content per se but the process of play that appeared to decrease anxiety and promote group cohesion. The children learned about others in the group through this valuable time before and after structured activities. There was also less distraction, since much of the structured activities were interrupted by those that were disruptive and had difficulty sitting still in structured activities.

Group members appeared to verbally respond more freely during free play than during structured planned activities. Although structured activities had defined purposes and objectives, free play allowed for personal expression without the control of an adult who directed their actions. Toys became their words and play their language. Children fought battles with super heroes and army men, cooked dinner, and played with puppets among other play activities in a relaxed accepting environment. Although the structured group activities provided time for a specific objective to be addressed; the time spent in *free play* appeared to be an important element in group therapy.
Conclusion for Qualitative Results

Methods used in collecting qualitative data involved multiple means of gathering data that entailed an extensive review of field notes of observations of groups, and recognizing themes in group sessions. The results may contribute to revisions and further development, of TGT which is a preliminary model for the purpose of increasing resiliency in first placement foster children. The following quantitative results reveal a complementary outcome.

Quantitative Results

Nonparametric tests were used for data analysis of quantitative measurements. The design employed in this study was a correlated group’s design wherein the same subject is measured twice (pre and post intervention). Due to the small sample size, both groups (experimental and wait-list control) were combined in the final analysis. To test the hypothesis that there will be a difference between pre-intervention and post-intervention scores on the Child Behavior Check List (CBCL), the Wilcoxon Signed Ranks Test was used. Scores on all eight subscales on the CBCL were tested for any significant difference. The total number of group participants was 11 children, but one group participant did not return instruments after the last group session, therefore was eliminated from the quantitative results. The following are the results of data analysis of CBCL and BERS. Descriptive statistics of the group participants of CBCL including number of participants mean of ranked subscales, and standard deviations.

The Child Behavior Checklist

As indicated in the table below, the subscales measuring anxious/depressed, rule breaking, and aggressive youth showed an asymptotic significance for a two tailed test for each subscales. Anxious/depressed subscale with \( p = .012 \) and rule breaking behavior and aggressive behavior profiles showed an asymptotic significance for a two tailed test slightly greater than .05 \( p = .057; \ p = .051 \). In the preliminary studies significant levels are set at less stringent levels and customarily set at .10.
Table 2.

Descriptive Statistics of CBCL

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>N</th>
<th>Mean Pre-test</th>
<th>Mean Post test</th>
<th>Std. Deviation Pre-test</th>
<th>Std. Deviation Post test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious/Depressed</td>
<td>10</td>
<td>7.70</td>
<td>4.60</td>
<td>4.572</td>
<td>3.978</td>
</tr>
<tr>
<td>Withdrawn/Depressed</td>
<td>10</td>
<td>3.40</td>
<td>2.10</td>
<td>4.115</td>
<td>2.558</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>10</td>
<td>3.50</td>
<td>2.50</td>
<td>2.321</td>
<td>2.759</td>
</tr>
<tr>
<td>Social Problems</td>
<td>10</td>
<td>6.30</td>
<td>5.10</td>
<td>2.830</td>
<td>4.306</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>10</td>
<td>5.80</td>
<td>4.90</td>
<td>3.824</td>
<td>3.900</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>10</td>
<td>8.60</td>
<td>7.00</td>
<td>5.91</td>
<td>4.110</td>
</tr>
<tr>
<td>Rule-Breaking Behavior</td>
<td>10</td>
<td>7.30</td>
<td>4.70</td>
<td>5.208</td>
<td>3.093</td>
</tr>
<tr>
<td>Aggressive Behavior</td>
<td>10</td>
<td>16.20</td>
<td>11.80</td>
<td>7.084</td>
<td>3.882</td>
</tr>
</tbody>
</table>

Note. A decrease in post test mean scores represents a decrease in behavior.

Anxious/depressed subscale. The syndromes associated with the anxious/depressed subscale involve the following: (a) cries a lot, (b) fears, (c) fears school, (d) fears doing bad, (e) must be perfect, (f) feels unloved, (g) feels worthless, (h) nervous, (i) fearful, (j) feels too guilty, (k) self-conscious, (l) talks of suicide and (m) worries. Anxiety and depression are common concerns among foster children. As described in the qualitative section of this document, children worry about adult issues and have a difficult time dealing with expression of emotions.
Many of these syndromes were targeted in group activities and it is promising that they showed improvement. In Table 3 scores reflect descriptive statistics and results of the Wilcoxon Signed Ranks Test of the anxious/depressed subscale on the CBCL.

Table 3.

**Wilcoxon Signed Ranks Test for Anxious/Depressed**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious/Depressed Post Test</td>
<td>8a</td>
<td>5.44</td>
<td>43.44</td>
</tr>
<tr>
<td>Anxious/Depressed</td>
<td>1b</td>
<td>1.50</td>
<td>1.50</td>
</tr>
<tr>
<td>Ties</td>
<td>1c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Anxious/Depressed Post Test < Anxious/Depressed  
b. Anxious/Depressed Post Test > Anxious/Depressed  
c. Anxious/Depressed Post Test = Anxious/Depressed  

Table 4.

**Test Statistics for Anxious /Depressed**

<table>
<thead>
<tr>
<th></th>
<th>Anxious/Depressed Post Test</th>
<th>Anxious/Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z</td>
<td>-2.499 a</td>
<td></td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.012</td>
<td></td>
</tr>
</tbody>
</table>

a. Based on positive ranks  
b. Wilcoxon Signed Ranks Test

**Rule-breaking subscale.** Rule-breaking behavior is a concern for foster children and many have numerous problems following rules and directions. The CBCL profile defined Rule-breaking behavior involves the following syndromes: (a) drinks alcohol, (b) lacks guilt, (c) breaks rules, (d) bad friends, (e) lies, cheats, (f) prefers older kids, (g) runs away, (h) sets fires, (i) sex problems, (j) steals at home, (k) steals outside home, (l) swearing, (m) thinks about sex
too much, (n) uses tobacco, (o) truant, (p) uses drugs, and (q) vandalism. Many group activities consisted of group discussion regarding the importance of complying with group rules and the importance of physical health. Also the camaraderie among group members appeared to help these children decrease acting out behavior due to acceptance of others and group trust. The table below reflects descriptive statistics and results of the Wilcoxon Signed Ranks test of the rule-breaking subscale on the CBCL.

Table 5.

Wilcoxon Signed Ranks Test for Rule Breaking Behavior

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule-Breaking Behavior Post Test</td>
<td>7a</td>
<td>5.50</td>
<td>38.50</td>
</tr>
<tr>
<td>Rule-Breaking Behavior</td>
<td>2b</td>
<td>3.25</td>
<td>6.50</td>
</tr>
<tr>
<td>Ties</td>
<td>1c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Rule-Breaking Behavior Post Test < Rule-Breaking Behavior
b. Rule-Breaking Behavior Post Test > Rule-Breaking Behavior
c. Rule-Breaking Behavior Post Test = Rule-Breaking Behavior

Table 6.

Test Statistics for Rule Breaking Behavior

<table>
<thead>
<tr>
<th>Rule-Breaking Behavior Post Test</th>
<th>Rule-Breaking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z</td>
<td>-1.904a</td>
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<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.057</td>
</tr>
</tbody>
</table>

a. Based on positive ranks
b. Wilcoxon Signed Ranks Test

Aggressive behavior subscale. Aggressive behavior can be problematic and foster children frequently have problems managing their anger. Uncontrolled anger may lead to a
plethora of problems for children. Aggression syndrome in regards to CBCL include the following profile: (a) argues a lot, (b) mean, (c) demands attention, (d) destroys own things, (e) disobedient at home, (f) gets into fights, (g) attacks people, (h) screams a lot, (i) stubborn, (j) mood changes, (k) sulks, (l) suspicious, (m) teases a lot, (n) temper, (o) threaten others, and (p) loud. This subscale showed significant improvement in the preliminary study. Group discussion focused on how to control anger and problem-solving. As indicated in the dialogue from Donald, he was not dealing with his anger but suppressing it and possibly releasing it on others. Table 7 reflects descriptive statistics and results of the Wilcoxon Signed Ranks Test of the aggressive behavior subscale on the CBCL.

Table 7.

*Wilcoxon Signed Ranks Test for Aggressive Behavior*

<table>
<thead>
<tr>
<th>Aggressive Behavior Post Test</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Ranks</td>
<td>7a</td>
<td>5.57</td>
<td>39.00</td>
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<tr>
<td>Positive Ranks</td>
<td>2b</td>
<td>3.00</td>
<td>6.00</td>
</tr>
<tr>
<td>Ties</td>
<td>1c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Aggressive Behavior Post Test < Aggressive Behavior
b. Aggressive Behavior Post Test > Aggressive Behavior
c. Aggressive Behavior Post Test = Aggressive Behavior
Table 8.

Test Statistics for Aggressive Behavior

<table>
<thead>
<tr>
<th></th>
<th>Aggressive Behavior Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive Behavior</td>
<td>-1.955&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.051</td>
</tr>
</tbody>
</table>

a. Based on positive ranks

b. Wilcoxon Signed Ranks Test

Table 9.

CBCL Subscales Test Statistics

<table>
<thead>
<tr>
<th></th>
<th>Withdrawn/Depressed Post Test</th>
<th>Somatic Complaints Post Test</th>
<th>Social Problems Post Test</th>
<th>Thought Problems Post Test</th>
<th>Attention Problems Post Test</th>
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<tbody>
<tr>
<td>Z</td>
<td>-1.023&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-1.065&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-1.205&lt;sup&gt;a&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.306</td>
<td>.287</td>
<td>.228</td>
<td>.512</td>
<td>.107</td>
</tr>
</tbody>
</table>

a. Based on positive ranks

b. Wilcoxon Signed Ranks Test

The Behavior and Emotional Rating Scale

Similarly, a Wilcoxon Signed Ranks Test was used to test if the intervention had made any significant impact on the parameters measured by the Behavioral and Emotional Rating Scale (BERS-2) post intervention. Pre and post scores on the five parameters measured by BERS-2 were tested to find if the intervention had made any impact. Data analyzed showed that there were three subscales, i.e. Interpersonal Strength, Family Involvement and School Functioning, that showed improvement in scores in the positive direction that were significant.
The Wilcoxon Signed Ranks Test indicated that the asymptotic significance for a two tailed test were significant (using .10 as the level of significance) for these subscales (Interpersonal strength, \( p = .05 \)).

Table 10.

*Descriptive Statistics for BERS*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Pre-test</th>
<th>Mean Post Test</th>
<th>Std. Deviation Pre-test</th>
<th>Std. Deviation Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpersonal Strength</strong></td>
<td>10</td>
<td>19.00</td>
<td>25.50</td>
<td>5.033</td>
<td>8.910</td>
</tr>
<tr>
<td><strong>Family Involvement</strong></td>
<td>10</td>
<td>16.80</td>
<td>20.70</td>
<td>3.584</td>
<td>6.056</td>
</tr>
<tr>
<td><strong>Intrapersonal Strengths</strong></td>
<td>10</td>
<td>20.10</td>
<td>25.10</td>
<td>7.141</td>
<td>8.279</td>
</tr>
<tr>
<td><strong>School Functioning</strong></td>
<td>10</td>
<td>12.50</td>
<td>17.50</td>
<td>5.622</td>
<td>11.028</td>
</tr>
<tr>
<td><strong>Affective Strength</strong></td>
<td>10</td>
<td>13.50</td>
<td>16.30</td>
<td>5.662</td>
<td>4.270</td>
</tr>
</tbody>
</table>

*Note.* An increase in post test mean scores represents an increase in strengths.
Table 11.

*Test Statistics for BERS Subscales*

<table>
<thead>
<tr>
<th></th>
<th>Interpersonal Strength Post Test</th>
<th>Family Involvement Post Test</th>
<th>Intrapersonal Strength Post Test</th>
<th>School Functioning Post Test</th>
<th>Affective Strength Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z</td>
<td>-1.960a</td>
<td>-1.684a</td>
<td>-1.482a</td>
<td>-2.102a</td>
<td>-1.483a</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.050</td>
<td>.092</td>
<td>.138</td>
<td>.036</td>
<td>.138</td>
</tr>
</tbody>
</table>

a. Based on negative ranks

b. Wilcoxon Signed Ranks Test

Those subscales that proved a significant change were *Interpersonal Strength* (*p* = .050), *Family Involvement* (*p* = .092), and *school functioning* (*p* = .036). These particular subscales appeared to include many of the subjects that were reviewed in group sessions. The following is a description of the three significant subscales:

*Interpersonal strength* is a subscale that includes the following questions: 1. I can express my anger in the right way, 2. if I hurt or upset others, I tell them I am sorry, 3. when my feelings are hurt, I stay calm, 4. I think about what could happen before I decide to do something, 5. I accept criticism, 6. I accept responsibility for my actions; 7. when I lose a game, I accept it, 8. I am a good listener, 9. when I make a mistake, I admit it, 10. I can deal with being told no, 11. I respect the rights of others, 12. I share with others, 13. when I do something wrong I say I am sorry, 14. I am nice to others, and 15. I use appropriate language. Many of these skills may have been acquired by participating in the group due to the social responsibility related to these questions. This was addressed in numerous group sessions.

*Family Involvement* subscale addressed the following questions: 1. My family makes me feel wanted, 2. I trust at least one person very much, 3. I join in community activities, 4. I get along well with my family, 5. My parents and I talk about how I act at home, 6. I get along well with my parents, 7. I go to religious activities, 8. I get along with my brothers and sisters, 9. I do
things with my family, and 10. I follow the rules at home. The fact that group participants
families were involved initially and at the final session, may have contributed to this increased in
family involvement. Looking systemically in the relational context of the child participation may
have been engaged the family and recursively affecting the child’s behavior as a result.

_School functioning_ subscale addressed the following questions: 1. I complete tasks when
asked, 2. I do my school work on time, 3. I complete my homework, 4. I pay attention in class, 5.
I am good at math, 6. I am good at reading, 7. I study for tests, 8. I attend school daily, and 9. I
listen during class and write things down to help me remember later. This was a surprising result
due to the fact that twice a week children attended group after school and had the possibility of
less time to complete homework and less attentiveness during school hours due to anticipation of
attending group.

**Conclusion of Quantitative Results**

Preliminary studies customarily use .10 as the level of significance to determine the
probability of change. Looking at results based on this probability level, four out of the eight
subscales on the CBCL revealed significant results and three out of the five subscales on the
BERS revealed significant results at post test. The following quantitative results include
comparisons of results of CBCL with BERS to determine overall effectiveness by utilizing
improvement in behavior vs. resiliency traits.

**CBCL Rule-Breaking and Aggression Subscales and BERS School Functioning Subscale**

Foster children may often have difficulty dealing with uncomfortable emotions such as
anger and have problems with decision making and solving problems as indicated in the
qualitative results section of this paper. In school they are often picked on by other classmates
and stigmatized for being a foster child. Qualitative results also indicate that children equate
anger with getting into fights and protecting themselves. Group participation not only decreased
rule-breaking (_p_ = .057) and aggressive behavior (_p_ = .051) in some children but also decreased
anxiety and depression (_p_ =.012) as well. This was also reflected in BERS results of behavior at
school which showed a significant increase in school functioning (_p_ = .036). Subscales in the
CBCL such as rule-breaking and aggression are described as behaviors that may contribute to
disruption at home and in community settings. It is promising that TGT contributed to significant improvement in children who participated in this group intervention.

**Anxiety/Depression Subscale on CBCL and Interpersonal Strength on BERS**

A decrease in anxiety and depressive symptoms also revealed significant results \((p = .012)\) on the CBCL subscale. The *anxiety/depressed* subscale on the CBCL was also carried over in the significance of the scores TGT participants displayed on the *Interpersonal strength* subscale of the BERS \((p = .05)\). Interpersonal strength was determined a recognized theme of group participants as indicated in the qualitative results section of this paper. Participation in TGT increased interpersonal *strength* and improved *school functioning* resulting in significant scores in BERS (Interpersonal strength; \(p = .05\); school functioning; \(p = .036\)). Visible observations also indicated that play and free group time decreased anxiety in participants as observed in field notes of group sessions. Other aspects of TGT that emphasized psycho education, expression of thoughts and feelings, and boundary activities may also have contributed to an overall decrease in anxiety and depression.

In comparing the results of significant scores of both measures it appears that TGT was effective in similar subscales on both instruments. Combining qualitative with quantitative results also adds to the soundness of the TGT intervention. In addition, those subscales that indicated the least amount of improvement such as *thought problems, withdrawn/depressed* and *social problems* subscales may indicate areas where TGT needs improvement. The *attention problems* subscale revealed borderline significant results. Attention problems were previously indicated as a barrier to implementation due to problems of co-occurring mental health conditions like ADHD among many group participants. In summary, the results of both measures may indicate that first placement foster children may benefit from their participation in TGT and the preliminary findings may also contribute to its future revisions.
CHAPTER 5

DISCUSSION

In view of the number of foster children in the United States and the extent of the emotional, physical, and social problems that exist in this population, an intervention was developed and implemented in an attempt to promote resiliency in first placement foster children. Intervening early, and utilizing a more preventive approach, appealed to this researcher as a possible solution to promote the individual and relational strengths that may be needed to inhibit negative influences of the foster care experience.

The purpose of this research, as described in chapter one, was to identify issues of foster children and develop an intervention to address these issues, and ultimately test the effectiveness of such an intervention, namely, TGT. Chapter two introduced the theoretical framework of resiliency, attachment, and development. The literature review also investigated the numerous challenges that foster children face while exploring play therapy, psycho-education, and group therapy as treatments for first placement foster children. Chapter three described the program of treatment and method intended to test the feasibility of TGT as a viable intervention. This discussion section will focus on chapter four and reviewing the overall results of this dissertation study.

The methods of conducting such a preliminary study presented many challenges. Putting TGT “in play”, and thereby discovering and documenting these challenges, was the key goal of the present study. In reflecting on the process of development and implementation of TGT, it is important to understand that all of the results were considered important pieces to the puzzle of what may be an effective intervention for first placement foster children. Determining what changes or revisions need to be made in the intervention and “what worked” and “what didn’t work” is instrumental in designing any revisions to TGT for future research. The feasibility and limitations of this research will be reviewed in this chapter. In Part I, the feasibility of TGT, including its potential promise, strengths, and contribution to the field will be discussed. In Part II, the limitations of this study and future revisions will be reviewed.
Part I- The Feasibility of TGT

TGT cannot simply be *installed*. Barriers to program ownership, participation, and fidelity will need to be addressed from TGT’s beginning to end. By studying lessons learned in the course of the present study, future TGT administrators can anticipate probable barriers, and find ways to deal with them. Future feedback from participant observers should lead to progressive refinement, and these processes will need to be carefully documented and made part of the dynamic document that is the TGT *Manual*.

Based on the present study, the next iteration of TGT will need to address the following issues:

- There must be a program director that is dedicated and committed to treatment standardization.
- Staff must be adequately trained in TGT, and have a shared interest in the welfare of foster children.
- Training in TGT must be focused on play therapy techniques, group therapy, common foster children issues, and foster family dynamics.
- Extensive training of all TGT personnel may be needed to handle situations that may occur in group sessions to maintain order and allow for a therapeutic environment conducive to change.
- Training of staff must be at different levels in relation to their role in the overall treatment.
- All TGT personnel must take ownership in the program. In so doing they must be committed to ongoing training in treatment quality and fidelity, and enthusiastic about their goals and objectives.
- Acceptance of the program cannot be taken for granted. Agency administrators and staff must see TGT as a means to their own ends, as opposed to a competitor for scarce time and energy. This also is true of the foster families. They need to see how TGT will meet their own needs for managing their wards and respite for themselves.
- Given the numerous barriers to implementation, persistence and focus of all program administrators will be required for success.
Those interested in TGT must operate in ways which maximize the potential for programs to acquire enough families to warrant their efforts. The program is only as strong as its value to the ownership in the larger community of family service providers in which it is situated. Overlapping roles and conflicting obligations, goals, and beliefs need to be identified. Ecosystemic and resiliency theories utilized in the development and implementation of TGT support the following insights.

- **Ecosystemic**: This cross-cultural approach recognizes that the personal attributes of a child are not all inclusive but include social circumstances resulting from an interactive dynamic within the community. Levels of factors affect human development and children have the capacity to adapt to their environment or tolerate diverse situations, and create the “ecology in which they live.” Within this approach we must consider behavior from a set of variables making up one’s individuality (life’s experiences, learning, life options, etc.) and one’s environment (psycho-social environment, social climate, interpersonal relation variable, etc.) (Munuz, 1998).

- **Resiliency**: In relation to the ecosystemic view, the resiliency of an individual child depends on the nature of interactions between of his/her individual personality and the characteristics of the ecosystem in which he/she develops. Each level of the ecosystem can generate risk factors as well as protective barriers. It is the interactions coming from different levels of the ecosystem that can cause one individual to encounter problems and another to become resilient (Garmezy, 1993).

**The Potential Promise of TGT**

As previously mentioned in this manuscript, foster children oftentimes get lost in the system that was designed to protect them (Haury, 2000). “Getting lost” may refer to the fact that foster children’s lives are directed by adults and they may never be given a voice in reference to available choices, or opportunities to express their thoughts and feelings. TGT is an attempt to intervene early in this process, in order to promote resiliency and allow foster children a “haven of safety and comfort” in a therapeutic environment. Nevertheless, even when children choose to participate in TGT, there are many individual differences in who they are and how they respond to the program.
TGT was developed according to the R & D model and involved the following steps: 1. determining a need, 2. planning a strategy for filling that need, and 3. developing a preliminary model of the strategy. These steps were essential in the organization and structure of this undertaking. The fact that TGT was implemented without outside funding and limited support, proves that an intervention can be executed if all steps are taken in the development and implementation of an intervention that targets a desired goal.

“What Worked”

The group activities and structure made up the core of TGT. These activities served a dual purpose; keeping children’s interest along with serving a therapeutic purpose. The concept of keeping children’s interest is reflected in the researcher’s view of creating a safe container or environment for which to change. This places the problems of the child second to forming of a therapeutic relationship with the child. This mirrors the researcher’s own view of counseling children and then introduces the process of isomorphism as a possible component to the development and implementation of an intervention.

Group sessions consisted of activities which included puppet play, various art activities, mask-making, sand tray play, and self-portraits. Psycho education involved self care and physical health added to activities that emphasized a holistic approach. Although, the lead therapist had limited training in play therapy, *free play* also was instrumental in the success of TGT, utilizing therapeutic toys to help process thoughts and feelings before and after sessions. As previously described in group themes, group camaraderie was formed between group members and children appeared comfortable with each another and bonded in TGT sessions.

Nevertheless, dissimilar children showed diverse responses to TGT, session by session, and with regard to outcome (see Appendix K). Amy appeared to benefit from more interaction with other children along with David, who has little interaction with others, besides school participation. Mark showed little or no improvement but was able to influence others by his actions and gave the TGT lead therapist an opportunity to teach or counsel based on his actions and responses. This shows the value of each and every participant that contributes their input into the group, and thus the benefits from participation in group therapy. It appears that diversity is the key to a unified and successful group experience.
Although the groups were diverse, TGT involved activities that targeted many developmental levels. Activities were geared toward children that would be applicable to many age groups. Psycho education during TGT group sessions was also developmentally appropriate for multiple age ranges. This allowed for a child to “learn” at their “level” of understanding.

In summary, reviewing “what worked” was vital to the continuation of this segment of TGT that may remain unaltered in future research endeavors and may contribute to the potential promise of utilizing TGT as a viable intervention for foster children.

**Strengths of Study**

Establishing a theoretical framework appears to have contributed to the strengths of this study. Influenced by an ecosystemic approach; resiliency, developmental, and attachment theories were the lens to view the overall process of development and implementation of TGT. The ecosystemic approach, which involved viewing the child in the context of his environment within the family, community, and society, was important in the overall success and evaluation of TGT. Although more support is needed for the implementation of TGT, the child was recognized as a part of a larger more, integral system. In the review and goal of promoting resiliency, specific goals and objectives based on this strength-based approach to treatment was initiated. All activities were viewed through a developmentally appropriate lens and it was discovered that no matter how diverse the group in age, race, personality type, or situation, TGT appeared to be developmentally appropriate and speak to all children at their “level” of understanding. The influence of attachment theory, which includes interactions and relationships, served as a foundation of overall goals and objectives of TGT.

Strengths of the study also centered on the TGT model, which included all the activities, structure, and group responses. Other strengths included the rigor and determination in which TGT was developed. This thoroughness involved an extensive literature review involving contributions of a wealth of information. The following topics will be reviewed as strengths to the study: 1. foster care literature, 2. resiliency literature, and 3. current available foster care interventions. Other strengths examined include the vast amount of qualitative information.
obtained by videotaping sessions and case study analysis. Lastly, quantitative results were viewed as strength in the usefulness of utilizing TGT with foster children.

**Review of Literature**

**Foster care literature.** Much can be gleaned by exploring the literature about the plethora of problems that foster children experience. In reading the vast amounts of literature proclaiming the numerous behavior problems and lifelong issues that foster children face, this in itself is a proclamation of the need for a preventive intervention to be developed. It is unclear to this researcher why such a dilemma exists in our society. Some topics that reappear and may need further investigation include: 1. irresolute utilization of group or therapeutic homes, 2. not acknowledging attachment problems by the use of multiple caregivers, 3. not listening to the voice of the child, and, and many others too numerous to mention. We appear to be continuing to victimize the children-who are victims themselves. These numerous behavior problems that are well documented (e.g. lying, stealing, etc.), may only be a symptom of the immense need for mental health and other professionals to answer to the needs of this vulnerable population.

**Review of literature on resiliency.** When reviewing this literature, this researcher understood that many of the definitions for resiliency are similar. The question continues to remain if this is an innate trait or can it be taught. When addressing resiliency you must also look at risk and protective factors of the child. This appears to be a factor in the development of the overall assessment of the child’s needs and strengths. As a result of this research, this researcher’s view of resiliency changed when Donald replied in regards to how to handle his worries, “Be brave,” he replied. At this pivotal moment of discovery, this helped me understand that resiliency can be explained and taught to children to give them the tools they need to buffer risk factors. They don’t have to simply be brave, but be prepared and informed about their situation and future. Being resilient may be simply developing and recognizing protective factors that include and are not limited to the view of MacDonald and Valdivieso, (2000). They defined their qualities as, 1. aspects of identity (self-confidence, future orientation, responsibility and connection), 2. areas of ability (including physical health and cultural identification), 3. expression and creativity, and 4. emotional and strategic supports. This researcher trusts that these qualities can be taught and promoted in foster children given the opportunity.
Current available interventions. A strong point of this study is that this researcher conducted an extensive search for available interventions for first placement foster children, to assess the need for a preventive intervention prior to this intervention research. The published work (Craven & Lee, 2006) was informative and confirming that no interventions exist initially when children are entering care. Since this researcher was a medical foster parent in 1995, services appear to have evolved to mental health now being more readily available to foster children. This service appears to be exclusive to when the child begins or is anticipated to have problems as a result of their removal from their primary caregivers. Weeks may sometimes turn into months before a child actually receives any services. TGT was created by this researcher, without any current intervention to compare or compete with. This speaks to the vulnerability and novelty of TGT as an initial attempt to promote resiliency in this research study.

Qualitative and Quantitative Results

Video-taping sessions. Video-taping is a process that involves multiple tasks for its success. The quality of the taping must be intact along with storing and organization. Despite its challenges, video-taping the sessions proved to provide an overabundance of information that could not be otherwise obtained. Not only were words and phrases observed and documented, but body language, facial expressions, and affect could be measured by this tedious viewing. This afforded this therapist a chance to see firsthand the experiences of TGT by its group members. This researcher was humbled by the observation and viewing of the content of these video-tapes and it proved to be the most inspirational, information gathering portion of this research.

Quantitative results of measures. Although this study was unable to provide a large enough sample to be considered a promising research study, quantitative results showed some significant changes in three subscales of CBCL and three subscales of BERS. This may not be indicative of a promising intervention but the results of the quantitative methods in combination with the qualitative results, appears to be strength of this study and warrants further investigation.
Contributions to the Field

The entire process of implementing this preliminary model may be helpful to others with an interest in the replication and design of any intervention. Any knowledge of the development and implementation of a new intervention and participation in research may inform clinicians possible methods to bridge the gap between research and practice. This endeavor, although arduous, reveals possible barriers to recruitment and implementation and the individual lessons learned. Contexts may change for certain presenting problems or circumstances but this may be utilized as a future model to direct future research in empirically testing new and current clinical interventions.

Utilization with Other Populations

TGT was designed specifically for children who are experiencing transitions. Many available interventions don’t target a specific population such as foster children, but may be appropriate for this treatment. Although this is a preliminary study, TGT offers promise for a possible intervention to promote resiliency that may be utilized for any children who face change and adjustment.

Due to the wide-ranging content of activities and objectives, TGT may also be utilized with other populations such as children of divorce, or for “first response” to any traumatic event (e.g. natural disaster, war, or accidents involving three or more children) to promote resiliency. Looking at the structure and organization of the TGT and the techniques and activities targeting specific resiliency characteristics, it may contribute to the field of play therapy, art therapy, and incorporate any model of therapy that is ‘at-risk “for trauma or distress.

Part II- Limitations of the Study

Limitations of the study were identified as the following: 1. Small sample size; therefore no comparison group, 2. Lack of follow-up posttest, 3. Lack of fidelity of treatment regarding play therapy, 5. researcher bias, and 6. threats to internal validity.
Small Sample Size

Due to the many barriers of recruitment of group participants, the study yielded a small sample size. A best practice approach involves having an adequate sample size to yield a true experimental study. Obtaining an adequate sample size of first placement foster children was quelled by problems related to recruitment among local agencies, families, and the community. This finding encourages a revision of a more diverse and assertive approach to recruitment. As previous described in lessons learned, building relationships with those in the community and more successful approaches may involve demonstrating how TGT may help them meet their obligations. Child-serving agencies defer to Officers of the Family Court and it may be possible to inform the Family Court about new interventions. A more sustained effort may yield a larger sample size.

Due to the small sample obtained for this study, a comparison group was not utilized. This was also viewed as a limitation and limited the overall generalizability of this research. A control group may be needed to address any threats to internal validity to be considered a “best practice” intervention.

Need for a Follow-up Posttest.

The first evaluation of TGT group results showed promise of an intervention to be utilized with first placement foster children. It would be beneficial to provide a follow-up test in six months or one year from completion of TGT to evaluate lasting effects of TGT.

Fidelity of Treatment

One important limitation to this study involved the lack of play therapy training on the part of the lead therapist who conducted TGT sessions. The researcher utilized therapists who were employed at CHS at the time of this research. The lead therapist had training in anger management and groups, but no training in play therapy. Although, three hours of training was provided by the researcher, this was not an adequate amount of training considering the hundreds of interactions that took place in the course of the treatment.

Typically, a play therapist is monitored and certified by the governing organization from
the American Association for Play therapy. A registered play therapist is required to receive 150
clock hours of training in addition to several hours of supervision. Although the field of play
therapy is growing, there were only four certified play therapists in the Tallahassee area at the
time of this study. Due to the fact that TGT was not funded by any outside sources, the
researcher utilized those therapists that were available at CHS at the time of the study. Future
revisions include more extensive training in play therapy and utilizing therapists that have future
interest in play therapy and working with foster children.

**Researcher Bias**

Although TGT was not executed by this researcher, this researcher recognizes that
researcher bias existed as a limitation to this study. The qualitative research paradigm contents
that the researcher is an important part of the process. It is in the interaction between the
researcher and researched that the knowledge is created so therefore the researcher sometimes
has problems separating from the research from beginning to end. So the researcher bias enters
into the picture even if the researcher tries to stay out of it.

This researcher admits that an emotional element existed in the development and
execution of this intervention. Determining a neutral stance was oftentimes a difficult process
and these challenges provided insight into my desired goal on the final outcome of this research.
Based on my past experience as a foster parent, and witnessing firsthand the problems that foster
children experienced, gives this researcher a “personal connection” to the outcome and
desirability to help foster children. In contrast, this may not be scientific, but this very human
emotional connection is what may be needed to motivate and make the required changes to help
a vulnerable population such as foster children. The firsthand experience by this researcher
provided this motivation.

What this researcher believes is that it is important to recognize that neutrality may be
unattainable when conducting such research. Measures can be employed to decrease the effects
of such an influence. A mixed method approach, utilizing qualitative along with sound
quantitative methods, may provide a more compelling argument to the effectiveness of any
intervention.
Threats to Internal Validity

Threats to internal validity are as follows: history, maturation, instrumentation, statistical regression, selection, subject mortality, and selection interactions. All of these threats posed a limitation on this research with the exception of subject mortality. All participants completed TGT and there were no dropouts in treatment.

A researcher can maximize internal validity by taking steps to minimize the potential threats to internal validity. Fraenkel and Wallen (1993) suggest four general ways in which these threats can be minimized. The techniques suggested for minimizing these threats and thereby maximizing the internal validity of a research study are as follows:

1. Standardization of the conditions under which the research study is carried out will help minimize threats to internal validity from history and instrumentation.
2. Obtaining as much information as possible about the participants in the research study aids in minimizing threats to internal validity from mortality and selection.
3. Obtaining as much information as possible about the procedural details of the research study, for example, where and when the study occurs minimizes threats to internal validity from history and instrumentation.
4. Choosing an appropriate research design can help control most other threats to internal validity.

Additional Revisions

Other possible revisions to TGT were based on the overall review of TGT results. These potential changes were based on the total group performance. Those changes include:

- Changing the closed group of 12 sessions to an ongoing open group
- Adding an individual therapy component to TGT
- Adding activities and discussions to decrease anxiety

Open Groups vs. Closed Groups

After reviewing the video tapes of group participants and the fact that participants formed group camaraderie, it may be more beneficial to offer open groups as opposed to closed groups. Group members may benefit from continuing their group participation to eliminate the
possibility of further trauma at the ending of significant relationships that were formed in the
group. This insight was gained in viewing video tapes and considering attachment issues that
foster children frequently encounter. The revision would not change the structure of the current
manual but it would leave the option of continuing group therapy at the discretion of the children
and their families. The groups would have the same agenda weekly and it would be ongoing for
six weeks at a time with the same schedule of activities.

Adding an Individual Therapy Component

Many group activities were not able to be processed in a group setting for various
reasons. In addition, many children brought up thoughts and feelings about specific problems or
concerns that merited further processing. Activities such as sand tray and artwork presented
challenges to foster children in a group setting. Not only did shy group participants have a
difficult time with some activities but outgoing and talkative children displayed impressionable
reactions to meaningful activities and discussions. While working on the same objective in group
format, individual therapy could be incorporated in combination with TGT. This may give the
child an opportunity to process any thoughts feelings about what occurred in the group session.

Focus on Activities that Decrease Anxiety

Due to the barrier to implementation previously described involving children displaying
ADHD symptoms in group, more activities are needed to decrease anxiety. Music was played in
one group session which demonstrated fewer incidents of the children needing to be redirected in
group. Other activities may include relaxation techniques and calming methods. Although CBCL
results indicated a decrease in externalizing behaviors in group participants, internalizing
disorders demonstrated some decrease but not reaching significant levels. Internalizing subscales
included withdrawn/depressed, and somatic complaints. These findings might suggest a need for
closer collaboration with other mental health providers such as psychiatrists/ family physicians
who are involved in the ongoing treatment and medical care of the child.
Final Conclusions

The American Academy of Pediatrics, (2000) claims that any intervention (e.g. foster care, kinship care, and residential care) that separates a child from the primary caregiver who provides psychological support should be cautiously considered and treated as a matter of urgency and profound importance. Programs should be designed to enhance “protective factors” and to move toward reversing or reducing known “risk factors.” The higher the risk for the target population, the more intensive the preventive effort must be, and the earlier it must begin (Coie et al.).

Transitional Group Therapy (TGT) for foster children was developed for the purpose of reversing the “risk factor” of foster care with the purpose of promoting resiliency. In reflecting on the existence of resiliency in a foster child, we may ask ourselves the question, “Are they really resilient prior or after entering foster care or just being brave and trying to please others?” According to Perry (1995) adults generally presume the most resilience in children during the most vulnerable time; during infancy and childhood. Perry added that the persistence of the destructive myth that “children are resilient” will prevent millions of children, and our society, from meeting their true potential (Perry et al, 1995). This researcher believes that it may be necessary to promote resiliency in first placement foster children despite the absence of any presenting problems initially when entering foster care.

This dissertation research has examined the research and development of Transitional Group Therapy (TGT) and identified barriers to recruitment and implementation. In addition, TGT was examined by means of both qualitative and quantitative methods. Results indicate that TGT may have potential as a promising practice that warrants further investigation. More research is needed to investigate the effectiveness of TGT by gleaning from the information obtained from the final conclusion and outcome of this feasibility study.
APPENDIX A

LOGIC MODEL
### Table K1. Logic Model

**PURPOSE:** To implement and evaluate a group therapy protocol to promote individual and relational resiliency in first placement foster children. This will prevent behavior problems from developing and teach traits necessary for the foster care experience.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>OUTPUTS</th>
<th>PARTICIPATION</th>
<th>OUTCOMES-IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TGT</td>
<td>What we do: 12 sessions</td>
<td>Who we treat:</td>
<td>SHORT-TERM GOALS:</td>
</tr>
<tr>
<td>1. TGT provided by therapists trained in treatment protocol</td>
<td>Stage 1 (Sessions 1-3) Establish rapport, overview of activities and goals</td>
<td>1. First placement foster Children</td>
<td>1. Ease transition to foster care</td>
</tr>
<tr>
<td>2. Treatment provided at Children's Home Society</td>
<td>Stage 2 (Sessions 4-7) Introduce resiliency traits (social competence, creativity, self-assurance, support, and expression of feelings and emotions</td>
<td>2. Ages 6-12</td>
<td>2. Reverse feelings of loss and abandonment</td>
</tr>
<tr>
<td>3. Therapists supervised by major professor over dissertation</td>
<td>Stage 3 (Sessions 8-12) Integration of knowledge gained by group participation</td>
<td>3. Major mental health problems excluded</td>
<td>3. Enhance self-control</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Develop inner sense of psychological permanence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. Decrease feelings of stigmatization</td>
</tr>
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</tbody>
</table>

### Notes

- **TGT** stands for the treatment group therapy.
- **SHORT-TERM GOALS:**
  - Ease transition to foster care
  - Reverse feelings of loss and abandonment
  - Enhance self-control
- **MID-TERM GOALS:**
  - Learn anger management and boundary issues
  - Increasing self esteem
- **LONG TERM GOALS:**
  - Children will demonstrate the following individual resiliency traits by participation in a relational resiliency milieu:
    - Self-confidence, connection, commitment to others, self-worth

APPENDIX B

TRANSITIONAL GROUP THERAPY MANUAL
SESSION ONE: *GETTING ACQUAINTED*

The first session will consist of the foster child and foster family. Each family member will introduce themselves and a family genogram will be constructed. Each family member will describe their family (e.g. children, pets, and home). Introduction of therapist and plans for future sessions will be discussed. Goals of therapy will be reviewed and group activities will be reviewed.

SESSION OBJECTIVE: Expectations and goals of group therapy. Building group cohesion and getting to know child and foster family.

HOMEWORK: Bring something that is special to you to group next week

SECOND SESSION: *GETTING ACQUAINTED*

**Ice-breaker-Have child share special item that he/she has brought to session**

The second session will consist of an introduction of group facilitators and group members. Facilitators will introduce themselves and ask group members to give their names, ages, grade in school, and something positive and personal about themselves. Using a flip chart group rules will be written and reviewed weekly. The rules will include; being respectful, no hitting, pushing, interrupting, name-calling and maintaining confidentiality. Confidentiality, respect for others and trust will be explained in detail. Group leaders will state the purpose of the group is to provide a place to explore and examine your personal potential and future goals, and to join with others who are in a similar situation.

SESSION ACTIVITY: Children will decorate folders/notebooks in which to keep handouts and pictures.

SESSION OBJECTIVE: Decrease stigmatization and increase group cohesiveness, establish structure in group

HOMEWORK: Ask the children to remember at least one name of a group member and something about that person.

SESSION THREE: *INTRODUCING RESILIENCY CHARACTERISTICS*

**Ice-breaker-Group sharing of one group member**

The third session we will discuss characteristics that make us stronger and prepare us for future. Discuss super heroes (e.g. power, strength). Who is you personal hero? Do I have at least one
person I can talk to, trust, show me how to do things right, help me learn how to do things on my own? Am I able to seek out support from others who care about me?

SESSION ACTIVITY: Decorate capes of your personal super hero. Using materials including art supplies (e.g. pom poms, fabric, glitter, feathers) create a super hero cape that represents your strengths and powers. Use the safety hand to elicit support from others. Who is presently available to call on if you need someone to talk to or ask a question?

SESSION OBJECTIVE: Using the super hero as a role model transcends the constraints of our own particular situations through the positive examples of others who model resiliency and inspire our strength and success. Super heroes represent mastery over problems. Also the Safety Hand exercise helps identify support in the present to focus on using resources to assist the child with their current needs.

HOMEWORK: Think about what questions you have about being placed in foster care and write down in journal-elicit help if needed.

SESSION FOUR: DEALING WITH UNCOMFORTABLE EMOTIONS

Ice-breaker-Share questions with group members

The fourth session we will discuss getting angry and the consequences of getting angry. Talk about impulsive behavior and thinking before acting. Teach children the feel, think, and do categories. Examples: Feel (in your body): heart pounding or racing, trembling, sweating, teeth clenching; Think (talking to yourself) I hate her! Why is this happening? Do: freeze, fight, run away, struggle, avoid. Explore music as a calming effect. Use a guided imagery and relaxation exercises to help find a safe place to retreat for calming.

SESSION ACTIVITY: Using paint and other arts and crafts create a drawing of a good day; then draw a bad day. Have each child talk about what they drew and why. Have the child dispose of picture anyway they desire. Read: The Little Engine Who could

SESSION OBJECTIVE: control emotions and regulate behavior-self control-increase self-worth

HOMEWORK: Think about what gifts and talents we have to give the world.

SESSION FIVE: WHAT ARE MY STRENGTHS?

Ice-breaker-Have children describe a strength or talent

In the fifth session we will discuss the uniqueness and individuality of group members and how we are all different but yet all the same. We will talk about strengths and positive attributes of each member. Discuss gifts and talents that group members have to share. How can we help
others as a result of our strengths and positive attributes? Have the children identified positive attributes and examples of situations they have handled well, using handouts-self-esteem, and valuing myself and exercise “I like me because…”

SESSION ACTIVITY: Using a variety of materials, have children choose a character to create into a puppet. Share character chosen and why they picked that character.

SESSION OBJECTIVE: Identify strengths through puppet play and act out; promote self-esteem and creativity

HOMEWORK; Think about a specific problem you would like to solve.

SESSION SIX: RESPONSIBILITY and PROBLEM-SOLVING

Ice-breaker-Share problem with group members

In the sixth session we will present scenarios of different situations and have group members create an ending. Discuss why he or she picked that ending and the appropriateness of it.

SESSION ACTIVITY: Have children pick a task they would like to help within the group such as: moving chairs, getting refreshments ready, or organizing art projects.

SESSION OBJECTIVE: Be a part of group, take responsibility

HOMEWORK: Think about how I can help others in a responsible way in the community

SESSION SEVEN: WHAT IS MY ROLE IN THIS FAMILY?

Ice-breaker-Describe what he/she can contribute to the community

In the seventh session we will discuss family roles, rules, values, and boundaries. Ask children about what their role in the family is. What chores do they do? What does their average day look like at home? How has it changed, and what would you wish it to be?

SESSION ACTIVITY: Ask children to create a sand tray. The sand tray will be about either, past, present, or future. Invite children to share sand tray with other group members (THEY ARE NOT REQUIRED TO SHARE).

SESSION OBJECTIVE: Using right brain activity to assess feelings and emotions and assists in processing events of the past, present, and future

HOMEWORK: What do I want to be when I grow up?

SESSION EIGHT: WHAT IS MY ROLE IN THE FUTURE?

Ice-breaker-Share what I want to be when I grow up
In the eight sessions we will discuss school and educational goals with children. How is school hard or easy? Is it easy making friends and getting along with others. What is their favorite activity at school?

SESSION ACTIVITY: Using a variety of art materials create a mask of what we want to be when we grow up such as: fireman, policeman, nurse, or teacher. Have children share their mask with other group members and role-play their character.

SESSION OBJECTIVE: Future oriented, instill hope about future. Personal goals

HOMEWORK: Who is my best friend? What makes him or her best friend?

SESSION NINE: OUR PHYSICAL HEALTH

Ice-breaker-Share who is my best friend and why

In the ninth session we will discuss in group about how our physical, emotional, and mental health is important. Discuss eating habits and the importance of sleep. Read a book about taking care of yourself and exercise.

SESSION ACTIVITY: As a group project create a salad or pizza with all healthy ingredients. Compare the salad or pizza with how we are all different and have come from different backgrounds. Eat pizza or salad together and enjoy!

SESSION OBJECTIVE: Promoting teamwork, working together, sharing, and taking care of our health by making good choices.

HOMEWORK: Bring to group next time a picture of foster family to share with others.

SESSION TEN: ACCEPTANCE AND TRUST

Ice-breaker-Share picture of family

In the tenth session we will discuss how some things we can change and other situations we cannot change. Talk about the process of acceptance and trust. Who do we trust and why? What does it mean to trust someone? When is it not good to trust a person?

SESSION ACTIVITY: Using a hula hoop have each child get in the hula hoop and talk about our own personal space and why it is important. Do an exercise on trust within the group. Get in a tight circle and have a child get in the center. Have each child fall against the others in the group to promote trust. Also do a movement exercise where we mirror the others movements in pairs.

SESSION OBJECTIVE: Establish appropriate boundaries, trust in others and develop social skills, instill hope for the future, relations with others, group cohesiveness.
HOMEWORK: Bring to the next group a picture of yourself to share with others.

SESSION ELEVEN: CREATING A POEM/SONG AND A SELF-PORTRAIT

Ice-breaker-Share picture of self

In the eleventh session we will discuss in group your favorite story or poem. Group leader will read poetry to children. Group leaders will do a role-play on their experience as leaders in the group, and share a personal poem they have written together.

SESSION ACTIVITY: Have children create a poem about their experience in the group. Provide children with art supplies to draw a self-portrait, and share with others their creations.

SESSION OBJECTIVE: Expression and creativity, sharing with others to promote group cohesiveness

HOMEWORK: Give foster parents an invitation to attend the final session party.

SESSION TWELVE: FINAL GROUP THERAPY WITH FAMILY

Ice-breaker-Share what you have learned by coming to group

Have children share their experience in group with others at final session. Have a ritual or ceremony marking graduation for the group. Give out certificates.

SESSION ACTIVITY: Join with families through food and music to celebrate their completion. Handout certificates of completion. Integration of group activities

SESSION OBJECTIVE: Integrate process of group sessions and have closure to learning and therapeutic experience
APPENDIX C

LETTER OF ENDORSEMENT FROM
CHILDREN’S HOME SOCIETY
Human Subjects Committee
2035 Paul Dirac Drive
100 Sliger Building Innovation Park
Tallahassee, Florida 32310

November 22, 2005

Committee Members:

Children’s Home Society is a statewide agency that provides a variety of services for children and families. We are also affiliated with the placement and case management of children who are in the custody of the state. We are in full support of the research proposed by Patricia Craven to conduct research at our facility. We have the space available including meeting rooms, play rooms, and a group room that has a two-way mirror.

In reviewing the aim statement provided by Patricia Craven, it appears that foster children who are first entering foster care may benefit from this service. We understand fully that Patricia will keep records confidential and locked up with access from other employees at CHS. We also had our corporate attorney review the IRB and the methods meet the standards of protocol for CHS.

Sincerely,

David W. Overstreet
Executive Director
Children’s Home Society

Mandi Moerland
Program Director
Family Connections

Date

Leave a Legacy... Remember Children’s Home Society of Florida in your estate planning.
APPENDIX D

HUMAN SUBJECTS COMMITTEE APPROVAL
FLORIDA STATE UNIVERSITY
APPROVAL MEMORANDUM

Date: 3/31/2006

To: Patricia Ann Craven  
1709 Indian Town Lane  
Tallahassee, FL 32312

Dept.: FAMILY & CHILD SCIENCE

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research: The Effectiveness of Transitional Group Therapy for Foster Children: Promoting Resiliency in Foster Children

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on 2/8/2006. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by 2/7/2007 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. The principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Robert Lee HSC No. 2005.1004
APPENDIX E

HUMAN SUBJECTS COMMITTEE APPROVAL
DEPARTMENT OF HEALTH
NOTIFICATION OF INSTITUTIONAL REVIEW BOARD APPROVAL

March 16, 2006

To: Craven, Patricia A.
Protocol Title: Transitional Group Therapy for Foster Children DOH IRB Number: H06020
Funding Agency:
Submission Type: Protocol H06020
Review Type: Expedited Review

Approval Date: March 16, 2006
2006 Expiration Date: March 15, 2007

The Department of Health Institutional Review Board, or representative, determined your study involves no more than minimal risk and meets the criteria for expedited review. It has been granted expedited approval. The study is approved for implementation.

As a reminder, the IRB must review and approve all human subjects research protocols at intervals appropriate to the degree of risk, but not less than once per year. **You are responsible for applying for renewal of this project at least 60 days prior to the expiration date of March 15, 2007.** This approval is valid for no more than one year. Re-approval is contingent upon IRB review and approval of a Continuing Review Report prior to the anniversary or expiration date of this approval.

Approval is contingent upon continued ethical research practice and your agreement to obtain informed consent and authorization from your subjects, unless waived. Please make certain that confidentiality is maintained. You must abide by the policies and procedures of the Florida Department of Health with regard to the use of human subjects in research, and keep appropriate records concerning your subjects.

**Investigators are required to notify the IRB in writing as soon as possible, but within 10 working days, of the occurrence of any adverse events, unanticipated problems, injuries, side effects, deaths, other problems involving risks to subjects, or deviations from federal or state regulations, or DOH policy.**

4052 Bald Cypress Way • Tallahassee, FL 32399
The IRB has approved exactly what was submitted. Any revisions to this protocol or consent form, no matter how minor, must be presented to the IRB for review and approval before implementation of the changes, except where necessary to eliminate hazard to human subjects. If a change is required to eliminate an immediate hazard, the IRB should be notified as soon as possible but no later than 10 working days.

Researchers are required to notify this IRB, in writing, in the event that this study is not implemented or when termination of this study takes place.

Research records must be maintained for three years after completion of the research; if the study involves medical treatment, it is recommended that records be maintained for eight years.

Please note that this protocol has been assigned the above-referenced DOH IRB protocol number. All inquiries and correspondence concerning this protocol must include (1) the above-referenced IRB number; (2) name of the principal investigator; and, (3) full title of study.

If you have any questions, or if we can be of any assistance, please contact the Department of Health IRB at (850) 245-4585 or toll-free in Florida (866)-433-2775. You may also visit our website at: http://www.doh.state.fl.us/execstaff/irb/

Thank you for your cooperation with the IRB.

Sincerely,

Robert Hood, Ph.D.
Ethics and Human Research Protection Program
Assistant Director, Office of Public Health Research

Federal Wide Assurance#: 00004682

4052 Bald Cypress Way • Tallahassee, FL 32399

End:
CONSENT FORM

Dear Parent:

I am a PhD student at Florida State University in the Department of Family and Child Sciences. I am pursuing a degree in Marriage and Family Therapy. I am conducting a study to evaluate the effectiveness of using Transitional Group Therapy for Foster Children at the Children's Home Society, Tallahassee, Florida.

Your child's participation will involve meeting two times a week for 6 weeks in a therapeutic group setting at the agency. We will discuss ways in which your child can build self-esteem and independence. The focus of the therapy will be building resiliency within your child. Group activities will involve sand play, puppet play, drawing, and role playing. Also meaningful discussions will be generated in an interactive group atmosphere.

I will be asking you to fill out questionnaires on behalf of your child to help me evaluate the effectiveness of the therapy. These questionnaires will be conducted at the beginning of therapy, at the end, and three months following completion. There will be no compensation for your participation other than the therapy itself. Your child will have many opportunities to be creative and benefit from his or her involvement. A personal notebook will be provided to each child at the completion of the intervention with skill building information and personal work completed during the course of the 6 weeks.

Your participation in the study, as well as your child's is voluntary. If you or your child chose not to participate or to withdraw from the study at any time, there will be no penalty.

The results of the study may be published, but you, or your child's name will never be used. All files of information of your child will be coded to secure the privacy of records. Confidentiality will be maintained at all times before, during, and following the study within the extent allowed by law. All video tapes will be destroyed following the completion of the analysis of data. They will be destroyed on or before July 1, 2009.

If you have any other questions regarding this research study or your child's participation, please feel free to contact me at anytime. My contact numbers are 850-921-8989 or 850-284-4246.

If you have any questions regarding your rights as a subject, or you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

Sincerely,

Patricia Ann Craven (850)921-8989

I give my consent for my child ______________________________ to participate in the above study.

Upon signing this consent form I am in agreement that my child will be videotaped for educational purposes.

Parent's Name ____________________________________________

Parent's Signature __________________________________________

Date

96
APPENDIX G

FOSTER PARENT INFORMED CONSENT
PARENTAL CONSENT FORM

Dear Foster Parent:

I am a PhD student at Florida State University in the Department of Family and Child Sciences. I am pursuing a degree in Marriage and Family Therapy. I am conducting a study to evaluate the effectiveness of using Transitional Group Therapy for Foster Children at the Children's Home Society, Tallahassee, Florida.

Your foster child's participation will involve meeting two times a week for 6 weeks in a therapeutic group setting at the center. We will discuss ways in which your foster child can build self-esteem and independence. The focus of the therapy will be building resiliency within your child. Group activities will involve sand play, puppet play, drawing, and role playing. Also meaningful discussions will be generated in an interactive group atmosphere. All sessions will be video taped. The video tapes will be destroyed following the completion of the study. All tapes will be destroyed on or before July 1, 2009.

I will be asking you to fill out questionnaires on behalf of your foster child to help me evaluate the effectiveness of the therapy. These questionnaires will be conducted at the beginning of therapy, at the end, and three months following completion. There will be no compensation for your participation other than the therapy itself. Your foster child will have many opportunities to be creative and benefit from his or her involvement. A notebook will be provided to each child at the completion of the intervention.

Your participation in the study, as well as your foster child's is voluntary. If you or your child chose not to participate or to withdraw from the study at any time, there will be no penalty.

The results of the study may be published, but you, or your foster child's name will never be used. All files of information of your child will be coded to secure the privacy of records. Confidentiality will be maintained at all times before, during, and following the study within the extent allowed by law.

If you have any other questions regarding this research study or your child's participation, please feel free to contact me at anytime. My contact numbers are 850-921-8989 and 850-284-4246. If you have any questions regarding your rights as a subject, or you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

Sincerely,

Patricia Ann Craven (850)921-8989

I give my consent for my child ____________________________ to participate in the above study.

Upon signing this consent form I am in agreement that my child will be videotaped for educational purposes.

Foster Parent's Name __________________________________________

Foster Parent's Signature _________________________________________

Date
APPENDIX H

CHILD ASSENT
Hello,_____________ my name Patricia. How are you doing today? I would like your help in doing a study for the benefit of foster children just like you. I want to find ways to make things easier for you to understand. As a part of this activity we will be getting together in a group with other children and talking about what you feel, think, and do. We will also do fun activities that involve playing with puppets and sand. A small part will be filling out paperwork and answering a lot of questions in the beginning and at the end. A large part of this activity will be getting know others in your group.

There is no right or wrong way you can act in this group. And, if you feel funny about any part of what we are doing, you don't have to join in. In fact you can stop at anytime and you will not get in trouble. So, if you agree to participate we can learn about yourself and others to help you understand what is happening in your life. So will you help me?

*If yes-Great,* let's get started. I am going to be writing down what you say because it is so important. Also, I am going to tape record every time we meet so I won't forget what you and others in the group have said. If you have any questions about what we are doing, just ask me. I will try to answer them so you can understand. Okay, are we ready to begin?

*If no-* If the child says "no", questions will be asked to determine if is an accurate response, such as "Do you have a dog?", "Do you like ice cream? If the child says "no" the second time, the child is free to go, and thanked for coming. The child is then dismissed from the study.
APPENDIX I

TGT CERTIFICATE OF COMPLETION
Certificate of participation in Transitional Group Therapy

“CHILDREN’S HOME SOCIETY”
NOVEMBER 16, 2006

This is to certify that _____ participated in Transitional Group Therapy and learned important resiliency skills such as: handling strong emotions, getting along with others, eliciting support, recognizing his special skills and uniqueness, eating healthy, exercising, and getting enough sleep. She also made puppets and masks, drew pictures, constructed a sand tray, among other play activities. The most important is that he participated in the group with all the other children.

Congratulations!

Awarded on the 16th day of November, 2006

Signed ________________________

Tony Richner, MA

Signed ________________________

Patricia Ann Graven, MS, LMFT, RPT

Signed ________________________

Clarissa Fountain, BS
Case Studies

After reflecting over each individual case reviewed in the field notes and videotapes of TGT, three cases were chosen for their uniqueness and contribution to the field. David, Amy, and Mark were evaluated using a mixed method approach of both qualitative and quantitative methods. David was chosen for his significant improvement of scores on both CBCL and BERS. Ann improved in some areas and Mark’s scores did not improve as a result of his participation in TGT but he offered meaningful responses and interactions. Each case study includes an evaluation of their group participation and responses, history, demographics, diagnosis, and risk and protective factors, and overall contribution to group cohesion. Foster family and lead therapist’s opinions of each individual case will also be included in the case study results. Names have been changed to protect the identity of children who participated.

Case Study: David

David is a seven-year-old African American male. He was referred for TGT by his grandmother to improve his behavior at home and at school. Grandmother wrote a personal letter to the researcher requesting her grandson participate. The family of five lives in a small trailer 30 miles outside of Tallahassee. The researcher provided transportation for David so he could participate in TGT with the permission of the clinical director of CHS.

David experienced extreme neglect while living with his mother the first four years of his life. He was deprived food and adequate physical and emotional care. It was also reported that David’s mother used cocaine and alcohol while she was pregnant with David. She left him and his older brother alone without food on several occasions. David was reported to have problems with defiance, inability to follow directions, low frustration and tolerance level, and anger. David struggles in school and is in special classes. The teacher stated that he stays to himself and has few friends.

David remained reserved throughout the group interactions and discussions. He also resisted participating in group activities. The group facilitator encouraged him to participate and he appeared to enjoy his time spent in TGT. He stated that he wanted to go into the army when he grew up. He also stated that his favorite activity was basketball. He won the basketball
tournament that was performed at the end of each session. The following is his self portrait which he didn’t chose to explain to the lead therapist or other group members. His mouth is missing and the portrait appears to be chaotic. This may be indicative of not having a voice in a chaotic world (Whiting & Lee, 2003).

Figure 1. David’s Self-Portrait

David showed improvement on both his internalizing and externalizing scores on the CBCL. He was able to score below borderline clinical range for internalizing behaviors and his total score was below any clinical range as a result of his participation in TGT.
Table 1. *CBCL Results for David*

<table>
<thead>
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<th>Subscales</th>
<th>Pre-test</th>
<th>Posttest</th>
<th>Difference</th>
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<tbody>
<tr>
<td>Internalizing</td>
<td>74**</td>
<td>48</td>
<td>-26</td>
</tr>
<tr>
<td>Externalizing</td>
<td>77**</td>
<td>64**</td>
<td>-13</td>
</tr>
<tr>
<td>Total Score</td>
<td>76**</td>
<td>58</td>
<td>-18</td>
</tr>
</tbody>
</table>

*Note.* **Represents a clinical level. *Represents a borderline clinical level. Lower scores represent a decrease in behavior problems.*

He improved in all area of the BERS and Intrapersonal strength was his greatest improvement profile.

Table 2. *BERS Results for David*

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal strength</td>
<td>14</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>Family involvement</td>
<td>11</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>Intrapersonal strength</td>
<td>8</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>School functioning</td>
<td>8</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Affective strength</td>
<td>2</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Total Score</td>
<td>45</td>
<td>87</td>
<td>42</td>
</tr>
</tbody>
</table>

*Note.* Higher scores represent an increase in strengths.

David’s primary caregiver is his grandmother and she was unable to attend any family sessions. Hence communication was possible only after the final group session when the researcher visited her home to fill out the posttest of CBCL and BERS. She stated she felt David’s behavior had improved and he looked forward to attending group therapy. The lead therapist stated that he saw an improvement in David in his self confidence and he progressively increased his interactions in group. David was liked by other group members.
Case Study: Amy

Amy is a seven year old Caucasian female who lives with her great aunt and uncle. She has lived with them since she was 17 months old. Amy’s mother is currently incarcerated in Virginia and has a problem with drug addiction. Her mother has had periodic visits with Amy and this has confused her and created problems for her current caregivers. Her father is unknown.

As a result of her mother’s heroin addiction, Amy contracted Hepatitis C. Amy is currently taking experimental drugs at Shands hospital which involve daily injections. She has no physical symptoms of the disease and has tolerated treatment well. The family drives Amy to Shands Hospital in Gainesville monthly for physical examination and blood work.

Amy has a shy personality at school and in a group setting. Her aunt and uncle describe her as “strong-willed” and “oppositional” at home. She has temper tantrums and demands her way at home. She has a hard time going to sleep and wets the bed and has been diagnosed with enuresis. She enjoys swimming, singing, crafts, and cooking. She also enjoys taking care of her rabbit.

Amy was quiet and reserved while participating in TGT. She seldom spoke up in group discussions and had a difficult time completing group activities such as self portrait and mask. She would begin the task and get frustrated and quiet, stating she didn’t like what she had done. During the course of group sessions, Amy began to blossom and she began to speak with a few other group members. She also began talking about her mother for brief periods between structured activities and playing during the free play time. Outgoing group members appeared to want to help Amy and would encourage her to participate. In one instance a group member got Amy to show everyone her duck call:

Kim: “Amy show us your duck call.”

Kim to group: “Raise your hand if you want Amy to show us her duck call.”

Amy to group: She forms her hand to her mouth and performs her duck call and everyone clapped.
In the final group session when everyone received their certificates, Amy hid under the table. Several group members reached under the table and encouraged Amy to come out and receive her certificate. Amy chose not to make a self portrait but with some prompting by the lead therapist made a sand tray of her family. Symbols used were female dolls, hairbrush, binoculars, and a teddy bear in wagon. The dolls may represent self-identity, closeness, nurturing, or relationships. The hairbrush, self image or self concept, binoculars may represent perspective, hunting and searching, and a teddy bear is a symbol of warmth, nurturing, security, and companionship (Norton & Norton, 2002).

![Amy’s Sand Tray](image)

Figure 2. *Amy’s Sand Tray*

Amy appeared to benefit from participation in TGT as indicated by her scores on the CBCL and BERS. Amy made significant progress in group therapy as indicated in Table 4. Her anxiety and shyness improved and by the time she had finished the six week group she was talking and expressing her thoughts and feelings. At one session she was able to express her thoughts about her mother to the lead therapist during a bathroom break.
Therapist: “Amy, You look like you want to say something”

Amy: “I do want to say something-I want to tell you what happened to my mom three weeks ago.”

Therapist: “Yes, go ahead.”

Amy: “My mom used to be in jail in Virginia Beach and I can’t be with her…cus my grandma Shelby had to work and my mom had to stay in jail.”

Kim intervened: “I thought that they would let you in to talk to her or something.”

Amy: “I can talk to her on the phone…and then she stayed at one of those houses so she won’t stay on drugs because my mom stays on drugs. She got in jail for driving without a driver’s license.”

Amy is still considered in the clinical range on the externalizing subscale and below clinical range on internalizing disorders. She displayed anger and aggression at home with her aunt and uncle and displayed no school problems, nor did she display any problems in the TGT group setting. Her overall improvements indicated on the CBCL were in the anxious/depressed, withdrawn/depressed, somatic complaints, social problems, rule-breaking behavior, aggressive behavior, and other problems subscale. On internalizing behaviors she went from clinical range to borderline clinical range at the completion of TGT.

Table 3. CBCL Results for Amy

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Pre-test</th>
<th>Post test</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing</td>
<td>70**</td>
<td>61*</td>
<td>-9</td>
</tr>
<tr>
<td>Externalizing</td>
<td>73**</td>
<td>66**</td>
<td>-7</td>
</tr>
<tr>
<td>Total Score</td>
<td>72**</td>
<td>65**</td>
<td>-7</td>
</tr>
</tbody>
</table>

*Note. **Represents a clinical level. *Represents a borderline clinical level. Lower scores represent a decrease in behavior problems.
Amy improved overall on her total scores for BERS. She improved the most in Interpersonal strength.

Table 4. *BERS Results for Amy*

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpersonal strength</strong></td>
<td>25</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>Family involvement</td>
<td>18</td>
<td>17</td>
<td>-1</td>
</tr>
<tr>
<td>Intrapersonal strength</td>
<td>33</td>
<td>31</td>
<td>-2</td>
</tr>
<tr>
<td>School functioning</td>
<td>18</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>Affective strength</td>
<td>20</td>
<td>12</td>
<td>-8</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td>114</td>
<td>125</td>
<td>11</td>
</tr>
</tbody>
</table>

*Note.* Higher scores represent an increase in strengths.

Amy’s aunt stated that Amy enjoyed coming to group and that as a result she could see an improvement in her behavior at home. She talked about group activities and discussed certain objectives that the group worked on after group. She continued having problems with her shyness and her initial reluctance to come to group. Her aunt stated that once she actually got to group her shyness dissipated. The lead therapist stated that Amy was beginning to open up and talk to him. It was the therapist opinion that Amy’s shyness had improved and she was feeling more confident.

**Case Study: Mark**

Mark is an 11 year old Caucasian male who was referred for TGT by his targeted case manager at Children’s Home Society. He has lived with his paternal grandmother for four years. He has a history of witnessing violent behavior in his environment. While living with his mother at a young age, his mother’s boyfriend put a gun to his head in a closet to keep him from talking when the police arrived to investigate drug use in the home. Mark is currently diagnosed with ADHD and has behavior problems at home and school. He also is diagnosed with encopresis and
enuresis.

Mark has an outgoing personality and he captured the attention of other children in the group. He displayed competitiveness in group sessions and sometimes demanded the attention of the therapist who facilitated group sessions. He also appeared irritated by the younger members of the group and had little patience when they copied his art work. Mark had problems with a few group activities that involved talking about feelings, including anger. One situation occurred during session four when another group member continued to try and get Mark to talk about why he gets mad and sad. Session four’s objective was to discuss getting angry and the consequences of getting angry. The objective was to process how one controls one’s emotions and regulates behavior. Mark became angry when the group talked about anger and consequences of getting angry:

Kim: “When I get angry I go to my room and cry.”

Justin: “I run away and cry.”

Therapist: “Mark, what do you do when you get angry?”

Mark: (no answer)

Kim: “Maybe he gets mad because his mom and dad are not together.”

Mark: “Blah, blah, blah…”

Mark: “The reason I am mad is because I don’t want to come here-I shouldn’t have signed the contract.”

Kim: “Maybe he is sad because his mom and dad are not together.”

Mark: “Don’t talk about me.”

Therapist: (to the entire group) “Do you think about what you do or do you just do it?”

Therapist: “Does anyone know what impulsive is?”
Kim: “It means you get angry like Mark is doing!”

Mark: “Quit talking about me, I don’t want to come here anymore.”

Mark was approached after this session to see if he wanted to continue in the group and he stated that he did want to continue. It was clear that he felt uncomfortable when he talked about his problems with anger.

In session 11, Mark displayed his low self worth after drawing a self-portrait. He drew fangs, and fire coming out of his mouth. He also drew horns on his head and his neck was made of scales. He exclaimed to others, “I’m ugly, look at me, I look like a mutant.”

Figure 3. Mark’s Self Portrait
During free play, Mark spent many sessions playing with army men, ninjas, knights, and warriors. He made elaborate battles and consistently stated, “I am going to blow your head off.” Mark was talkative, outgoing, and participated in group activities and was often the first to respond to questions and he had perfect answers. He also told stories about his family and spoke about his father whom is not a part of his life. Mark appears to want normalcy in his life and has a personality that attracts others to him. He has a sense of humor and is creative and playful. He also has problems with anger and controls other with violent statements he makes. Children were asked to create a sand tray of their family. The following is a sand tray that may depict his inner battle. Sand tray symbols that Mark selected were war symbols that may represent aggression, conflict, rage, destruction, revenge, and relationship (Norton & Norton, 2002).

Figure 4. Mark’s and Tray

Mark’s results on the CBCL indicated that his behavior did not improve as a result of his participation in TGT (see Table 5).
Table 5. **CBCL Results for Mark**

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing</td>
<td>41</td>
<td>45</td>
<td>+4</td>
</tr>
<tr>
<td>Externalizing</td>
<td>71**</td>
<td>67**</td>
<td>-4</td>
</tr>
<tr>
<td>Total Problems</td>
<td>66**</td>
<td>66**</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note.** Represents a clinical level. *Represents a borderline clinical level. Lower scores represent a decrease in behavior problems.

In measuring Mark’s level of resiliency scores indicated that participating in TGT decreased resiliency traits. It was later revealed that Mark had been in a residential group home for two years prior to living with his grandmother.

Table 6. **BERS Results for Mark**

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal strength</td>
<td>20</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Family involvement</td>
<td>22</td>
<td>16</td>
<td>-6</td>
</tr>
<tr>
<td>Intrapersonal strength</td>
<td>26</td>
<td>23</td>
<td>-3</td>
</tr>
<tr>
<td>School functioning</td>
<td>4</td>
<td>3</td>
<td>-1</td>
</tr>
<tr>
<td>Affective strength</td>
<td>19</td>
<td>16</td>
<td>-3</td>
</tr>
<tr>
<td>Total Score</td>
<td>91</td>
<td>78</td>
<td>-13</td>
</tr>
</tbody>
</table>

*Note.** Higher scores represent an increase in strengths

Mark complained about being with the other children who appeared to him as immature. The lead therapist thought that Mark had made significant gains and that he enjoyed the interaction with other group members despite his complaints.
Case Study Conclusions

All three children made their individual contribution to the group. These individual personality traits along with past experiences added to the ambience of each group. These case studies are a small illustration of the measure of the many problems that exist for children who are removed from their primary caregivers. Each case illustrates the influence of this removal and its systemic effect it places on each person as it touches their lives.
REFERENCES


*Psychology in Spain, 2*(1), 11-16.

Myeroff, R., Mertlich, G., & Gross, J. (1999). Comparative effectiveness of holding 

Naastrom, K., & Koch, S. M. (1996) Addressing the needs of children in out-of-home 
care. Paper presented at the 28th annual meeting of the National Association of School 
Psychologists, Atlanta, GA.

Francisco, CA: National Adolescent Healthy Information Center, University of 
California, San Francisco.


experiential approach.* Denver, CO: White Apple Press.


impairment in children of women who smoke cigarettes during pregnancy. *Pediatrics, 
93*, 228-233.

*Journal of Social Issues, 54*, 425-446.

Crisis Center Model: A proactive multidimensional child and family assessment process.* 
The Child Trauma Academy.

The neurobiology of adaption, and “use-dependent” development of the brain: How 

Services, 46*, 906-910.


Rosenfeld, A. A., Pilowsky, D. J., Fine, P., Thorpe, M., Fein, E., Simms, M. O., Halfon, 


BIOGRAPHICAL SKETCH

PATRICIA ANN CRAVEN

EDUCATION

PhD, Marriage and Family Therapy-2008
Florida State University, Tallahassee, Florida - Dissertation topic: The Effectiveness of Transitional Group Therapy: Promoting Resiliency in Foster Children

MA, Marriage and Family Therapy- 2002
Appalachian State University, Boone, North Carolina

BA, Psychology- 1999
University of Central Florida, Orlando, Florida

Diploma, Nursing- 1991
Forsyth Technical Community College, Winston Salem, North Carolina

TEACHING EXPERIENCE

Instructor-2004
Valdosta State University, Valdosta Georgia -Treatment Issues, MFTH 7601 and MFTH 7650 graduate level students in the Marriage and Family Therapy Program, Direct supervisor: Dr. Kate Warner, MFT Program Director.

Instructor-2004
Tallahassee Community College, Tallahassee, Florida - Responsible for teaching a adult education class mandated by the court in Florida to obtain a divorce. The title of the course: Parents, Children, and Divorce. Direct supervisor: Bridget Elwell, Adult Education.

Instructor-2002
Florida State University, Tallahassee, Florida - Responsible for teaching large undergraduate classes, FAD 2230, Family Relations. Direct supervisor: Dr. Carol Darling

Instructor-2001
Appalachian State University, Boone, North Carolina - Responsible for teaching incoming freshman a course titled: Freshman Seminar. Direct supervisor: Dr. Laurie Williamson.

PRESENTATIONS

- Healing Play Therapy Toys and Techniques for At-Risk Children, FAPT, Orlando, Florida 2008
- Early Brain Development and Foster Children, AAMFT, Austin, Texas, 2007
Couples and Art therapy, FAPT, Daytona Beach, Florida 2006
The Power of Play, Children’s Home Society, Tallahassee, Florida, April, 2006
Clinical Interventions in Family and Couple Play Therapy, FAPT, Orlando, Florida, April, 2006
Attachment Disorders in Children and Adolescents, Wilmington, NC, Carolina Rehabilitation, 2005
Ritualized Interventions in Couples Therapy, Appalachian State University, Boone, NC, Family Institute, 2004
Family Strengths, Head Start, Tallahassee, Florida, 2004
Healing Rituals for Couples Recovering from Adultery, American Association for Marriage and Family Therapy Annual Conference, Long Beach, California, 2003
The Mother's Role in the Etiology of Psychopathology in Major Clinical Journals, American Association for Marriage and Family Therapy Annual Conference, Long Beach, California, 2003
Healing Rituals for Couples Recovering from Adultery, North Carolina Association for Marriage and Family Therapy, Charlotte, North Carolina, 2002
Becoming Culturally Competent Therapists, North Carolina Association for Marriage and Family Therapy, Raleigh, North Carolina, 2001

PUBLICATIONS

Refereed Articles:


Work in Progress:


Book Chapters:


LICENSES AND CERTIFICATIONS

- Marriage and Family Therapist-Florida, License # MT 2156
- Marriage and Family Therapist Supervisor
- Social work Internship Supervisor
- Mental Health counselor Supervisor
- Registered Play Therapist, Supervisor, APT
- Marriage and Family Therapist-North Carolina, License # 1068

CLINICAL TRAINING AND EXPERIENCE

- Learning Perspectives, Inc. 2005- Provided child therapy to children and adolescents in an out-patient setting.
- Marriage and Family Therapist, Marriage and Family Therapy Center, Tallahassee, FL, 2002 - 2004 Provided family therapy as well as individual and couples therapy to students and members of the surrounding community Family Counselor,
- Intensive Crisis Counseling Services, Tallahassee, Florida, 2002 to 2005 - Conducted home-based therapy to families at risk of removal of their children due to abuse, neglect or other safety issues. This work involved traveling to surrounding counties, doing consultations and assessments. It Involved Psycho education on domestic violence prevention, positive parenting, and substance abuse were often addressed with at-risk families.
- Medical Family Therapy Intern, Wake Forest University, Winston Salem, NC, 2001 to 2002 – Under the supervision of Dr. Wayne Denton-screened clients in the Department of Psychiatry at Baptist Hospital. Also maintained several clients during the course of internship to receive 575 hours of direct contact. Participated in a Marriage and Family Therapy Clinic research and collaboration with psychiatric residents.
ASSOCIATIONS

- American Association for Marriage and Family Therapy-Clinical Member
- Florida Association for Marriage and Family Therapy
- Tallahassee Association for Marriage and Family therapy
- Association for Play Therapy
- Florida Association for Play Therapy, Florida
- Tallahassee Association for Play Therapy-Secretary/Treasurer 2008-2009
- Department of Family and Child Sciences, Marriage and Family Therapy Graduate Association, Florida State University, 2002 - Treasurer & PhD Representative

RESEARCH ACTIVITIES

Florida State University, Tallahassee, Florida, 2006  Research was conducted with first time placement foster children ages 6-12 in a group setting to promote resiliency. This is a six week intensive short-term preventive intervention to assist foster children to survive the foster care experience.

Florida State University/Appalachian State University 2002-2005 - Content Analysis: The Mother's Role in the Etiology of Psychopathology in Major Clinical Journals. The content analysis involved the coding of articles from 6 scientific journals by creating and utilizing a code sheet designed to determine if mother-blaming exists in psychological literature.

Partnership for Stability, Toy Industry foundation, Florida State University, 2003 - Submitted grant for funding to create a parenting link between foster parents and biological parents for the best interests of foster children-unfunded

Appalachian State University, Boone, North Carolina, 2002 – Under the supervision and direction of Dr. Wayne Denton, data was collected for a study involving the use of the Global Assessment of Relational Functioning (GARF) and the Classification of Relational Disorders (CORD). This was conducted at Wake Forest University School of Medicine, Department of Psychiatry and Behavioral Medicine, Winston Salem, NC. Weekly measurements were used to assess couples in the Marriage and Family Therapy Clinic to evaluate their relationship according to the GARF and CORD. This involved compiling data among therapists and psychiatric interns.

Wake Forest University, Winston Salem, NC – Under the supervision and direction of Dr. Wayne Denton and Dr. Stephanie Walsh data was collected for the SHARE study (Synthesizing Health and Relationship Enhancement) I conducted couples therapy utilizing Emotionally Focused Therapy to couples where one or both partners were diagnosed with a somatoform disorder. Extensive training was involved in working with couples, weekly supervision, and taping of all sessions.
PROFESSIONAL ACTIVITIES

- Secretary/Treasurer Tallahassee Association for Play Therapy 2008-2009
- Student Representative, Faculty Policy Member, Florida State University, 2003
- Treasurer/PhD Representative, Marriage and Family Graduate Association, Florida State University, 2002 to 2004
- Student Representative of Senate for Department, Graduate Student Association Senate, Appalachian State University, 2001 - Appointed by Department Chair
- Study Abroad, Department of Human Development and Psychological Counseling, Bolivia, South America, 2002 - Traveled with a group of professionals and students to Bolivia, South America and participated in visiting shelter homes for the poor, lectured in school settings, and attended cultural activities.

HONORS AND AWARDS

- Hortense Glenn Honor Society, Florida State University, 2004 - Upper 1% chosen for honorary membership. First pick of students.
- Kappa Omicron Nu National Honor Society, Florida State University, 2003
- Tyner Scholar Award, Department of Family and Child Sciences, Florida State University, 2002
- Graduate Research Award, North Carolina Association for Marriage and Family Therapy, Charlotte, NC, 2002
- Honorable Mention-Teaching Award, Reich College of Education, Appalachian State University, 2002
- National Honor Society for Graduate Students and Professionals, Alpha Epsilon Lambda, Boone, NC, 2002
- Jones-Dotson Scholarship Recipient, Department of Human Development and Psychological Counseling, Appalachian State University, 2001
- National Honor Society in Psychology, Psi Chi, University of Central Florida, 1997
- Academic Honors, Deans List/Presidents List, University of Central Florida, 1995 to 1999
- Research and Sponsored Programs, Graduate School Scholarship Recipient, Appalachian State University, 2001