EVALUATION OF A THERAPEUTIC GROUP INTERVENTION PROGRAMME FOR CHILDREN WHO WITNESS SPOUSAL VIOLENCE

BY

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2008
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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy (PhD) in Community Psychology in the Department of Psychology at the University of Zululand.

Promoter: Prof. N.V. Makunga

2008
DECLARATION

I, Thamaga Jankie Mamphekgo hereby declare that this thesis is my own work and that all sources I have quoted have been acknowledged by means of complete reference.

____________________
TJ Mamphekgo

January 2008
DEDICATION

The most important task God can give is the opportunity to be a parent. It is in this spirit that I dedicate this thesis to my two daughters, Mmabatho and Tshegofatso for the satisfaction gained from being their father.
ACKNOWLEDGEMENTS

During the writing of this thesis a number of individuals and organizations gave assistance and support. The following list serves to acknowledge and thank them for their support.

Professor N.V. Makunga, for her patience, keen interest, constructive criticism, constant encouragement and valuable suggestions while supervising; Professor S.D. Edwards and the staff of the Department of Psychology, University of Zululand, for their guidance, friendly support and patience during my course of study.

Sarah Lekale who acted as a co-therapist during group session with participants involved in the study. Her constant support, both technical and moral is highly appreciated. She is a shining star.

The children and mothers who agreed to participate in this study. Their cooperation made it possible to obtain the data necessary for this project.
The staff of the Goldfields Family Advice Organization, for their keen interest and cooperation. Thanks go especially to the manager of this organization, for arranging with families for interviews and group sessions.

Tokolo Mazui, my partner in private practice, for his endless support and encouragement during stressful times.

Nomaciko, Tshidi and Bev, for making the typing of the completed thesis a problem-free exercise.

I also wish to express my thanks to Prof. C. T. Moyo of the Department of General Linguistics, University of Zululand for proof reading the document, and

A big "THANK YOU" to my wife Mieta, for her invaluable assistance from the first draft to the last. Only a loving wife would endure the social deprivation associated with the writing of a thesis. Love and appreciation to you Mieta.
Evidence from literature (Edleson, 1999; Rossman, 1998; Graham-Bermann, 1996) has shown that children who witnessed family violence suffer from emotional, behavioural, social and cognitive problems and are often in conflict with the law and adults. For this reason, the main aim of the present study was to form and evaluate a therapeutic group for children who witnessed family violence in an attempt to promote health at secondary and tertiary levels.

The sample for this study consisted of 12 children aged 8-13 years (who constituted the therapeutic group) and their mothers (who evaluated children’s progress). Specifically designed questionnaires were used to collect data which was analyzed by using descriptive statistics.

The findings of the study showed that children who witnessed family violence benefited from group therapy as a treatment approach. Children’s post-test responses showed a significant improvement when compared to pre-test responses. This was also affirmed by mothers’ post-test responses. These findings suggest a critical need for provision of group therapy to children who witnessed family violence.
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CHAPTER 1

GENERAL ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The extent of wife abuse has been well-documented over the past years (Martin, 1976; Straus, Gelles & Steinmetz, 1980; Walker, 1979). However, not much has been written about children who witnessed spousal violence. Supporting this notion Rosenberg and Rossman (1990) point out that children who witnessed their parents violence have only been recently targeted as a unique population warranting research and therapeutic intervention. This particular group of children may have witnessed acts of physical and psychological violence between their parents or between a parent and an intimate partner.

Evidence from literature (Allessi & Hearn, 1984; Edleson, 1999; Hilberman & Munson, 1977-78; Hughes & Barad, 1983; Jaffe, Wolfe, Wilson & Zak, 1986; Ulbricht & Huber, 1981; Westra & Martin, 1981) is that a child's exposure to family violence has diverse and long lasting negative effects. Mamphekgo (1994) agrees that these children experience a myriad of emotional, social and behavioural problems. Observable behavioural effects include: withdrawal, running away from home, destructive behaviour, fear, enuresis, hyper dependence, school phobia, somatic complaints, nightmares, tics, insomnia and
decreased self-esteem, amongst others. Documented also, is the correlation between witnessing abuse as a child and becoming abused or an abuser as an adult (MacEwen & Barling, 1988; Owens & Strause, 1975; Post, Willet, Franks, House & Back, 1981).

From the discussion above, it is clear that children who have witnessed spousal violence do have specific problems and needs that must be addressed through therapeutic interventions.

1.2 RESEARCH PROBLEM

The Goldfields Family Advice Organization in Welkom has been inundated with providing psychological help to women of various ages and diverse socio-economic backgrounds who were abused by intimate partners. Discussions with colleagues from similar organizations elsewhere have revealed that children of women who were abused by intimate partners often need to be assisted with psychological interventions for behavioural, emotional and academic problems. These observations are supported by Lawrence's (1984) study which revealed that most mental health professionals assisted children, who witnessed their mother's abuse, with counselling.

Since children who have witnessed family violence seem to be at risk to a host of psychological problems, the present research wishes to explore whether a therapeutic group intervention program can assist in addressing the problems of
these affected children. A question raised here is: can psychological problems experienced by children who witnessed spousal violence be addressed in a group setting? Put differently, can group therapy contribute in improving the quality of life of children who witnessed spousal violence?

1.3 MOTIVATION FOR THE STUDY

According to Carlson (1984) using group work with children is more encouraging than individual intervention. However, only few evaluations on group work with children have been reported (Jaffe, Wilson & Wolfe, 1989) and most of these evaluation studies were conducted in America and Britain.

To date, in South Africa there has been no study undertaken which specifically focused on the evaluation of a therapeutic group intervention program for children who witnessed spousal or family violence. In the present study, the researcher attempts to fill this void by conceptualizing group therapy as a “social action program” in terms of the Community Psychology Perspective (Edwards, 1999). Hage (2000) stresses that indeed, a Community Psychologist who uses the group therapy/counselling model can effectively provide an out-reach service to this group of children who are at-risk and even refer to them as “forgotten victims of family violence.”
1.4 THE AIM OF THE STUDY

The proposed main aim of the present study was to determine the impact of group therapy in addressing the psychological problems experienced by children who witnessed spousal/family violence.

1.5 THE OBJECTIVES OF THE STUDY

• To tap the experiences of children who witnessed spousal violence.
• To establish a therapeutic group for children who witnessed spousal violence and evaluate its effectiveness.

1.6 HYPOTHESES

Group therapy will result in:
• Decrease of emotional, social, behavioural and cognitive problems of children who witnessed spousal/family violence;
• Improvement of quality of life of children who witnessed spousal/family violence and
• Positive appraisal of group therapy by mothers of children in respect of children’s learning, handling of conflict and use of appropriate conflict resolution skills.
1.7 SCOPE AND LIMITATION OF THE STUDY

In view of practical considerations the present study was conducted at the shelter for abused women run by the Goldfield's Family Advice Organization in Welkom, a town situated in the Free State Province (see Figure 1).

Figure 1: Map showing the location of the shelter run by Goldfields Family Advice Organization
1.8 VALUE OF THE STUDY

It is hoped that the findings of the study should be of benefit to:

- children who witnessed spousal abuse by improving their quality of life;
- personnel working with children who have witnessed spousal abuse by providing a therapeutic tool that can be of benefit when treating these children and
- Research field of study by being used as a framework for generating future research and generating new perspectives in the area of group therapy particularly with children.

1.9 DEFINITION OF TERMS

1.9.1 Evaluation

Evidence from literature (Trochim, 2006) points out that evaluation is a systematic acquisition and assessment of information to provide useful feedback about some object. According to this definition evaluation entails collecting and sifting through data, making judgements about the validity of the information and of inferences we derive from it.
1.9.2 Therapeutic Group

A therapeutic group is regarded as a small group of clients with similar psychological problems who are treated by one or several therapists in a group using “talk” therapy or other therapeutic forms such as expressive therapy and psychodrama. In support of this notion the Medical Encyclopedia (2007) and Barnard and MacKenzie (1994) express that a therapeutic group is a form of psychosocial treatment where a small group of patients meet regularly to talk, interact, and discuss problems with each other and the group leader (therapist). Similarly, the American Heritage dictionaries refers to a therapeutic group as a form of psychotherapy that involves sessions guided by a therapist and attended by several clients, who confront their personal problems together; the Britannica Concise Encyclopedia regards it as a “form of psychotherapy in which several patients or clients discuss their personal problems, usually in the presence of a therapist or counsellor”; and the Columbi Encyclopedia (2007) considers it as “a process carried out in formally organized groups of three or more individuals who seek change”,

1.9.3 Intervention Programme

This concept which is borrowed from public health terminology refers to the science and art of preventing pathology, thus prolonging life, promoting physical and mental well being as well as efficiency (Graham-Bermann, 2000).
1.9.4 Children

According to The Oxford Mini-dictionary (1990) the term “children” is a plural of the noun “child”, which means a young human being, who is either a son or a daughter. Robertson (1989) explains that a child is any person under the age of 18 years. Since there are different views around the definition of the term “child”, in this study the definition given in the Child Care Act 74 of 1983 was used. Thus, for the purpose of the present study, the age range for a child will be from 8 to 12 years. This restrictive definition was adopted to accommodate the nature of the population used in this study as it was considered that younger children might find it difficult to articulate their experiences.

1.9.5 Witness to spousal violence

Although according to Mohr, Noone, Lutz, Fantuzzo & Perry (2000) there is no widely accepted definition proposed in the literature regarding the concept “witness to family violence”, there is some consensus in explaining the various ways in which children can experience partner abuse (Edleson, 1999). This includes seeing the violence, being part of the violence, or more commonly, hearing the violent event and experiencing its aftermath (e.g., an injured parent, police intervention, or moving to a shelter). Edleson (1999) proposes a broad definition of “witnessing family violence” that incorporates all these experiences. However, Sudermann and Jaffe (1997) suggest that it is more appropriate to refer
to a child's **exposure** to violence rather than referring to a child as being a **witness** to violence, due to the latter's connotation of having viewed the violence firsthand.

The present study will use the terms "exposure" and "witness" interchangeably, with the understanding that "witnessing" violence does not necessarily only entail direct observation of a violent event, but that it may also entail hearing the violence and being affected by its aftermath.

### 1.9.6 Shelter for Abused Women

According to Peled and Davis (1995) a Shelter for abused woman is a temporary accommodation where women who have left their abusive partners are offered emotional, legal and psychological support.

### 1.9.7 Goldfields Family Advice Organization

The Goldfields Family Advice Organization (GFAO) which was established in 1997 is a support system for abused women with the main objective of empowering women who are victims of domestic violence. It has a close working relationship with the departments of Justice and Social Welfare as well as local non-governmental organisations.
1.10 CHAPTER OUTLAY

The study will be discussed over five (5) chapters. The first chapter gives a general overview to the study. The aims and objectives of the study are highlighted and hypotheses are identified. Definitions of pertinent terms used in the study are clarified. Lastly, the scope of the study is briefly discussed.

The second chapter explores literature relevant to the study.

Included in chapter three is the research methodology for the present study. Details relating to the sample and the instrument used are provided. Ethical considerations relevant to the study are also explored and explained.

The analysis and interpretation of the results are included in chapter four. The fifth and final chapter in this study provides a discussion of the results as they relate to current literature and similar studies. Conclusions are drawn from the results and limitations of the study are noted. The chapter concludes with recommendations addressing the need to raise awareness and dispel myths regarding children who witness spousal violence.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Intimate partner violence is a common problem. Evidence from literature (Statistics Canada – Catalogue No.85-002-XIE, Vol.21 70.6; Nevid, Rathus & Greene, 2000) shows that women are much more likely than men to suffer severe abuse by a marital or common-law spouse during their lifetime. As indicated by Dauvergne and Johnson (2001) victims of spousal abuse always report that their children witness the violence against them. Groves (1999) also, acknowledged that more than 5 million children in the United States of America witness violence between their parents. Yet, attention has generally focussed on the impact of violence on victims and less so on the children who witnessed the violence. Since Jaffe, Wolfe and Wilson (1990) have shown that witnessing violence can have an impact on children's development, this chapter examines theoretical and empirical literature on children who witnessed interparental violence and who for many years had remained the “unintended” victims of family violence.

In this Chapter, different theoretical explanations are put forward to account for the impact of witnessing spousal violence on child behaviour. Negative consequences of child witnessing spousal violence are discussed. Factors
influencing the degree to which a child witness is affected are described and group therapy as a treatment approach used to assist affected children cope with life is outlined.

2.2 THEORETICAL ACCOUNT OF SPOUSAL VIOLENCE ON WITNESSING CHILD’S BEHAVIOUR DEVELOPMENT

Some explanations put forward to account for the impact spousal violence has on behaviour development of the witnessing child are discussed in this subsection.

2.2.1 Social Learning Theory

According to Bandura (1961, 1973) the social learning theory states that individuals learn new behaviours by observing the reaction of salient models around them, such as parents, teachers, television heroes etc, and by storing these behaviours in their memories in the form of mental images and other symbolic representations. Bandura (1961, 1973) calls this process observational learning and believes that this is the main way through which children acquire new patterns of social behaviour. This theory suggests that parental violence can negatively affect the witnessing children, since these children observe and model the negative behaviour displayed by the fighting parents. This factor is diagrammatically depicted by Figure 2.
Bandura (1973) explains that observation of learning occurs at a covert, cognitive level. By paying close attention to a model's actions and by forming mental representations of the model's behaviour, children can learn and retain a vast repertoire of complicated new behaviour patterns.
In his review of the modelling hypothesis, Bandura, (1973) noted that modelling does not only consist of the mimicry of behaviour, but there are two other aspects involved. Firstly, modelling involves the acquisition of information about the behaviour. For example, if parents are hostile and aggressive during conflicts, children may learn that aggression is an acceptable way to deal with disagreements. Grych and Fincham (1990) noted that this belief is more likely to be expressed in age-appropriate ways, because children who learn to be aggressive through conflict situations might not be aggressive towards their more powerful parents, but may instead act aggressively when interacting with peers or younger children. This notion is supported by Cummings, Ian-notti and Zahn-Waxler, (1985) who observed in their study that children who witnessed family violence exhibited increased physical and age-appropriate aggression toward their playmates. Secondly, modelling may also have a dis-inhibitory effect on children's behaviour. Exposing children to aggressive models may give children permission to be aggressive.

Children are also more likely to learn such behaviours from the media, that is television personalities when exposed to television. Bandura (1973) agrees that children tend to pay close attention to and learn behaviour appropriate for members of their own sex than that of the opposite sex. He further explains that children also tend to learn more about models who are powerful or perceived to be similar to themselves. Stressing this view, Emery (1982) stated that boys compared to girls in aggressive situations are more likely to imitate their fathers. This view suggests that boys are, in general, more likely to imitate aggressive
behaviour than are girls. Therefore, the observed sex difference in response to marital violence may simply be a subset of this general sex difference. Davidson (1978) stated that boys believe their fathers are not only powerful, but also right and they emulate their behaviour so as not to be frightened by their violence and power. In support of this statement Davidson (1978) cites an example where male toddlers kick and hit their mothers to gain attention and pre-teen or teenagers pick up the expected pattern and actually join in the beating of their mother. Joining in the attack with the batterer offers children the safety of siding with the winner. This example is in keeping with the psychoanalytic view as proposed by Freud (1946), that boys tend to use their father's superego role model and internalise their actions.

This view suggests that physical aggression in the home provides both a model for learning aggressive behaviour and a supportive environment that views such behaviour as appropriate (Widom, 1989), Straus, Gelles and Steinmetz, (1980) accept that by being a participant member of a violent family, each new generation of children learns how to be violent towards their own family members.

In a review of television violence and its relation to the cycle-of-violence hypothesis, Widom (1989) noted that exposure to television violence has been determined as a factor that leads to increased levels of aggression in some viewers, to have long-term effects as well as effects immediately after exposure, and to emotional desensitisation. Widom (1989) notes also that intensive
television viewing may lead to distorted perceptions about real life violence among both adults and children.

This hypothesis suggests a linear relationship that is, the children who witness family violence are more likely to engage in similar patterns later on in their families, hence the “violence begets violence” hypothesis (Widom, 1989). Research findings (Straus et al., 1980) also support the social learning thesis that training in violence is generalizable across settings and across targets.

2.2.2 Attachment Theory

Bowlby (1951) the proponent of the attachment theory when considering the origins of mental health and illness states: “... what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother in which both find satisfaction and enjoyment” (p.11).

The child’s relationship with the mother contributes significantly to the development of personality and psychological problems, to the extent that when the child does not have a conjusive relationship, the term “maternal deprivation” is used. According to this theory, a critical function of attachment is to establish transactional patterns between the mother and infant that can be used to resolve the state of disequilibrium, thus contributing to the infant’s affect regulation.
Davis (1991) stated that lack of or inappropriate attachment will interfere with the infant's ability to maintain regulation of affect and this can result in the infant losing confidence in the capacity of the attachment relationship to restore affective equilibrium. As a result, the infant may turn away from the attachment and defensively begin to rely on the self to regulate affect. Davis (1991) contended that because such autonomous regulation of affects is beyond the infant's developmental abilities, these infants will appear to be symptomatic-depressed, withdrawn, anxious, affectively disorganized or behaviourally disordered. Bowlby (1951) attributed the reason for the development of these problems to the lack of an opportunity for developing an attachment to a mother figure, deprivation for a limited period, and deprivation of mother’s love.

In support of Bowlby (1951) literature endorses that when insecurely attached as an infant your internal working models of attachment relationships will include the use of aggression, to gain power and control. These internal working models are then brought to adult relationships with intimate partners. The intergenerational transmission of violence occurs when children who witness episodes of violence in their homes, or experience violence directly as victims, become aggressive in adult relationships (McNeal & Amato, 1998).

Bowlby's (1951) work led to numerous independent studies, which confirmed and echoed the conclusion of each other. Of particular relevance to Bowlby were the Tschann, Johnston, Kline and Wallerstein (1989) and Jouriles, Barling and O'Leary (1989) findings. It was respectively found that pre-divorce marital
conflict was related to post-separation behaviour problems and emotional adjustment only indirectly through its association with the quality of parent-child relationships (attachment bond).

2.2.3 Family Systems Theory and the Intergenerational Transmission of Violence

This model was proposed by Minuchin (1974; 1985). In general, systems theories hold that an initial maladaptive behaviour usually results from the interaction of learning and response patterns experienced in the home environment. Put differently in a family, members may use violent means to maintain equilibrium in the family system. In intimate partner violence in an attempt to gain control, family members are actually increasing the dysfunction of the family. Investigating Psychology accepts that this model can provide explanations of children's reactions to inter-parental conflict. (Drum Magazine 2007, Emery, 1982, 1988, 1989). This model highlights the emotional regulation and a functionalist perspective on emotional expression (Bretherton, Fritz, Zahn-Waxler & Ridgeway 1986). Emery (1989) outlines the children's reactions to their parents' conflict in terms of a three-component process whereby:

- the conflict serves as an aversive event that creates distress in the child;
- the child reacts emotionally or instrumentally in an attempt to alleviate the distress, and
• the child's actions that serve to reduce the conflict and which are likely to be maintained because of the function they serve for the child and for the family as a whole

The first component stipulated by Emery (1989) is supported by the work of Cummings, Iannotti and Zahn-Waxler (1985), who noted that anger between adults is distressing to children who witness them. In laboratory analogues involving simulated fights between strangers (Cummings, 1987), children as young as 12 months old have been found to respond to episodes of anger not directed at them with signs of distress ranging from crying to increased aggression. Emery (1982) further indicated that exposure to anger directly causes negative emotional reactions in children, even when they are third parties to the conflict.

The second component of the model suggests that children's distress motivates them to respond emotionally or instrumentally to the conflict. Instrumental responses to parental conflict have been documented by observations of children's behaviour during laboratory simulation (Cummings, Iannotti & Zahn-Waxler, 1985), and reports of battered woman about their children's reactions to marital violence (Barnett, cited in Emery, 1989).

The third component of the model relates to the function that the child's response serves for the child and the family. According to this component, since distress is aversive, responses that reduce distress should be negatively reinforced. Some
responses may be internal, cognitive or affective coping processes, but others may be actions that serve interpersonal as well as individual functions. This component suggests that parents may be distracted from their conflicts and drawn together in mutual concern for the child, therefore reducing family distress by shifting concern from a more threatening marital problem to a less threatening child problem, thus serving a homeostatic function for the larger family system. Minuchin (1974, 1985) calls this scapegoating. This distraction, according to Emery (1989), serves an interpersonal function.

According to Jaffe, Wolfe, Wilson and Zak (1986a), children with violent parents have high probability of learning that: (a) conflict is resolved through violence; (b) interaction of family members contains violence; and (c) violence is sanctioned as a mode of stress management. Wagar and Rodway (1995) suggest that the extent to which children learn these lessons is mediated by their propensity to identify with their parents and model the behaviour in question.

2.2.4 Cognitive-Contextual Theory

The cognitive-contextual framework focuses on the child's attempt to understand and respond to an episode of marital conflict (Grych & Finchman, 1990). This framework conceptualises inter-parental conflict as a stressor for the child. Hence, it outlines processes that may moderate the stressfulness of conflict for the child and highlights the importance of the context of parental conflict and children's cognitive level of development. The model further proposes that both
cognition and affect serve appraisal functions and guides the child's coping behaviour. Figure 3 highlights the Components of the cognitive contextual framework as explicated by Grych and Fincham (1990).

**Figure 3. Components of the Cognitive-Contextual Framework For Understanding A Child's Response To Marital Conflict Grych & Fincham (1990).**
This theory concurs with Lazarus' (2000) theory of stress and coping, which postulates that several antecedents to the stress responses are highly influenced by the individual's level of cognitive, moral, and social development (see Figure 4).

Figure 4. Components of Lazarus' (2000) Stress and Coping Theory
When the primary appraisal of a stressor is harm, loss, threat, or challenge, secondary appraisal involves identifying coping resources. In the short-term, the stress responses are manifested as a biopsychosocial response and emotions. A number of studies support the idea that both cognitive and affect save functions and guide coping behaviour (Ryan-Wenger & Sharrer, 2005; Sharrer & Ryan-Wenger, 2002).

2.3 NEGATIVE CONSEQUENCES OF WITNESSING PARENTAL VIOLENCE

Psychological effects that can emerge following witnessing spousal violence by a child include the following:

2.3.1 Post Traumatic Stress Disorder

Exposure to violence seems to trigger Post Traumatic Stress Disorders (PTSD) in children more often than in other Stressors (Pynoos & Eth, 1986).

Evidence from literature (Pynoos & Eth, 1984; Pynoos & Nader, 1988) shows that 100% of children who witnessed parental homicide or who witnessed a mother's violent sexual assault by strangers fitted the diagnosis of PTSD. Since PTSD results from overwhelming levels of fear and helplessness, combined with perceptions that one is going to be killed or seriously injured, so it is easy to see how PTSD could be triggered by exposure to partner violence. However, it is not
clear how many children who witness less serious forms of partner violence may suffer from PTSD.

In one study of 64, seven to twelve year old children whose mothers had been assaulted by partners in the past year, 13 % were found to be suffering from clinically diagnosable PTSD, while the majority of children exhibited some PTSD symptomatology: 52% experienced intrusive, unwanted memories of traumatic events, 19% exhibited traumatic avoidance, and 16% suffered from traumatic arousal symptoms (Graham-Bermann, 1996).

Symptoms of Post Traumatic Stress Disorder in children given by (DSM-IV-TR (2002) are:

A. Re-experiencing the traumatic event
   1) Recurrent, intrusive distressing recollections of the event
      Persistent, unwanted thoughts
      Repetitive play including aspects of the traumatic event
   2) Bad dreams and nightmares
   3) Acting or feeling as if the event were happening again, including flashbacks
   4) Distressing in response to reminders of the event emotional distress, physical reactions such as shakiness, increased heartache, headaches, sick feelings
B. Avoiding stimuli associated with the event (including numbing of general responsiveness).

1) Attempts to avoid thoughts or feelings associated with, or that arouse

   Recollections of the event
   Trying not to think about what happened
   Avoiding people and places associated with the traumatic event

2) Inability to remember certain aspects of what happened

3) Losing interest in significant activities

4) Feeling detached or estranged from others

5) Feeling numb

6) Sense of a foreshortened future

C. Persistent, increased arousal

1) Difficulty falling or staying asleep

2) Irritability or outburst of anger

3) Difficulty concentrating

4) Hyper vigilance, constantly watching out for danger

5) Exaggerated startle response (jumpiness)

2.3.2 Behavioural and Emotional Problems

Levine (1975) studied inter-parental violence and its effects on the witnessing children. His findings indicated that the majority of children who witnessed
family violence experienced both emotional and behavioural problems. Behaviour problems observed included truancy, aggression, setting fire to furniture, and extreme bullying of younger siblings. At school the aggressive behaviour was found to be demonstrated by hostility to both teachers and other children. Emotional problems included anxiety, worrying, specific fears, phobias and withdrawal. These problems resulted in some children playing truant from school.

Hilberman and Munson (1977-78) in their study of children of violent marriages compared the psychological adjustment of three groups of boys. Their sample comprised of 209 boys. One group had been abused and had also witnessed severe marital violence; and the third group (control) had not witnessed nor experienced abuse. The case history method was used to gather data about these children. The researchers found that compared to those in the control group, boys in both groups exposed to violence manifested some form of behaviour and emotional problems. Behaviour problems such as truancy, running away from home, stealing, violence towards others and peer group members as well as temper tantrums were noted. Emotional problems included school phobias, enuresis, insomnia, anxiety and fears.

These findings revealed that those in the group who were abused and witnessed marital abuse manifested severe behavioural and emotional problems as compared to those in the group who just witnessed marital abuse without being abused themselves. These findings, suggest that the intensity and the extent of
marital abuse are important factors in determining the effect of marital violence on the witnessing children.

The above study involved boys only; hence, their generalization to girls was questionable. Addressing this limitation, Davis and Carlson (1987) replicated the study of Hilberman and Munson (1977-78) and further extended it by including girls. The completed sample included 34 pre-schoolers, ranging in age from 4 to 5 years (15 girls and 19 boys), 32 school age children, ranging in age from 6 to 11 years (17 girls and 8 boys), and 11 adolescents, ranging in age from 12 to 16 years (3 girls and 8 boys). Because of the small numbers in the adolescent sample, data from this category was not analysed. Similar to results of Hilberman and Munson's study, it was found that 70% of the children presented with behaviour problems which included: aggressive behaviours towards peer members, temper tantrums, and truancy at school. Emotional problems included anxiety, depression, somatic complaints and fears. Age and gender differences were evident in this study. More boys were in the clinical range of behaviour problems during Pre School than the school years, while fewer girls were in the clinical range during the pre-school than school years. The conclusion from the above two studies were echoed by Jaffe, Wolfe, Wilson & Zak (1986) who concluded that "witnessing violence and being its victim both are related to the extent of behavioural problems exhibited by children, with some evidence that the combination of being a witness and being a victim has more serious consequence" (p76).
Wolfe, Jaffe, Wilson and Zak (1985) studied behaviours and social competence of children from violent homes. The researchers used Achenbach’s Child Behaviour Checklist (Achenbach & Edelbrock, 1982). The sample comprised 102 children. The parents of these children were asked to rate their children on the above-mentioned scale. The researchers found that 34% of the boys and 20% of the girls fell within the clinical range of behaviour problems which included aggression, truancy, stealing and running away from home. In this sample, 46% of girls fell within the clinical range of emotional problems and only 20% of boys fell within the clinical range. These findings suggest that boys are more likely to manifest behaviour problems than girls and girls are more likely to manifest emotional problems than boys.

Many studies have found that children who are witnesses to family violence have behavioural difficulties at rates higher than the average population. Results using the Child Behaviour Checklist (Achenbach & Edelbrock, 1982) and similar methods have found increased rates of externalising behaviour problems among these children who witnessed spousal violence (Edleson, 1999; Hughes, 1988; Rossman & Ho, 2000). Child witnesses are described as more hostile, aggressive, violent, and antisocial than those who are not exposed to violence (Edleson, 1999). They are also at high risk for substance abuse, running away from home, engaging in prostitution, and committing violent sexual crimes (Wolfe, Wekerle, Reitzel, & Gough, 1995). One large scale study found that child witnesses to family violence (boys and girls) were two times more likely to act out aggressively than children who did not witness violence, even after controlling for socio-
demographic variables, social support, parenting, behaviour, and child emotional problems (Hughes, 1988). Overall, boys in both groups were more violent than girls.

Kashani and Allan (1998) noted that one of the most frequently mentioned impact of witnessing violence is the potential for the development of trauma symptoms, especially among children who witnessed the murder of one parent by another. In fact, witnessing violence as a child has been established as a risk factor for the development of Post Traumatic Stress Disorder (PTSD) in children. (Arroyo & Eth, 1995; Rossman, 1998). Lehman (1997) found that 56% of children in a battered women's shelter met diagnostic criteria for PTSD and most of the other children demonstrated varying levels of PTSD symptoms.

Using a more diverse sample of child witness to family violence and more stringent diagnostic criteria, Graham-Bermann and Levendosky (1998) found that 13% of their sample met DSM-IV (American Psychiatric Association, 2000) criteria for PTSD; many more of the children demonstrated sub-clinical levels of trauma symptoms. Rossman (1998) and Rossman and Ho (2000) also found that children who had witnessed family violence demonstrated higher levels of PTSD symptoms than a control group. Johnston, Gonzalez and Campbell (1987) researched 56 children who varied in racial and socioeconomic origin. At the entry into the study, they ranged in age from 4 to 12 years. All these children accompanied their mothers after divorce. They were assessed at two points: at the time of the dispute and 2.5 years later. The researchers found that the extent of
the child's witnessing parental violence predicted behavioural problems, like aggression and acting out behaviours at the time of the dispute. The same factors, together with the rate of verbal aggression between parents, predicted total behaviour problems and emotional problems. Behaviour problems included aggression and emotional problem included somatic complaints, withdrawal and depression.

In other studies Kalmus (1984) and Sudermann & Jaffe (1997) found boys who witness their fathers battering their mothers to be significantly more likely to use violence themselves. These results support other researchers studies findings (Allessi & Hearn, 1984; Emery, 1982; Hage, 2000; Henderson, 1990; Hughes, 1988; and Rosenberg, 1984) where boys showed more behaviour problems than girls and girls showed more emotional problems than boys. However, one retrospective investigation found that exposure to marital violence was associated with increased levels of aggression for girls only (Forsstrom-Cohen & Rosenbaum, 1985).

Thus, from the studies reviewed it is evident that children exposed to inter-parental violence are prone to emotional and behavioural problems. This literature suggests that children from violent homes are more likely to display emotional and behavioural problems than children from non-violent homes.
2.3.3 Cognitive Functioning

Studies have investigated the effects of witnessing spousal abuse on cognitive and social-problem solving abilities of children who witnessed family violence. Westra and Martin (1981) conducted a study on the cognitive abilities of children of battered women by comparing the functioning of the children to standardized norms on the McCarthy scale of children's abilities. The sample comprised 20 children who witnessed marital violence and were victims of marital violence. The age range of the sample was 2.5 years to 8 years with an average of 5.2 years. The researchers found that children of battered women scored significantly lower than a standardized population on the verbal, quantitative, motor, and general cognitive index of the McCarthy measure. In a similar study, Pfouts, Schopler and Henley (1982) researched the cognitive ability of children who witnessed marital abuse. The sample comprised 25 children who witnessed family violence and their ages were not reported. Case histories and interviews with social workers in charge of the shelter were conducted. There were global reports of school failures, loss of concentration in class, and an ability to cope with their schoolwork.

Similar findings are expressed in a South African Study. Lawrence (1984) researched spousal abuse and their children at Mitchel's Plain, Cape Town. Her sample comprised 45 abused women. The purpose of the study was to determine the extent of wife abuse at Mitchel's Plain. Social workers and other health professionals were interviewed to gather data about the children from these
families. The researcher found that the majority of children in her sample presented with various cognitive problems including poor school performance, concentration difficulties, school refusal, school dropouts, school failures and poor memories.

Rosenberg (1984) conducted research on the children of marital violence. 34 children formed her sample with ages ranging from 4 years to 12 years. Case histories and parental interviews were used to gather information about the children's cognitive functioning. The researcher found that most of the children were experiencing school failures, concentration difficulties, were easily disturbed, achieved below their grade level in school, attempted to avoid tasks that required sustained attention, and were experiencing difficulties in coping with their school work. The findings of Rosenberg were echoed by Hughes (1986) who in the sample of 110 children from violent homes, found that these children manifest various cognitive problems including poor school performance, and poor concentration level that had affected their schoolwork.

Naidoo (1992) conducted a study of 50 violent families and their children of school-going age, (between 8 years and 13 years). School reports and mothers interviews were used to gather information about the cognitive functioning of these children. Teachers were also interviewed about behaviour and school performance of these children. The researcher found that 76% of children exposed to conjugal violence were academically maladjusted. These children
experienced learning difficulties including poor concentration, school failure, inability to cope with schoolwork and failure to adjust to schoolwork.

In another study, Weldin, Williamson, and Wilson (1991) examined the developmental and learning profiles of 76 children of 39 mothers, who were victims of domestic violence in a pilot survey. Approximately 40% of the preschool children had developmental delays and were at risk for developing future school problems. Nearly one-half of the school-aged children had one or more indicators of academic problems (e.g. grade repetition, failing grades, need for special services.

According to Rossman (1998) and Rossman and Ho (2000), this cognitive decline may be due to decreased information intake and/or decreased cognitive processing skills. The arousal symptoms of PTSD in child witness to family violence has also been linked to attention difficulties in these children.

2.3.4 Social functioning and problem solving abilities

Empirical investigation on the child witness population has focussed on the child’s social functioning and conflict resolution skills. There are studies that offered support to the idea that children’s social-problem-solving abilities are affected by witnessing their parents’ violence. Bandura (1973) hypothesized that children who witnessed their parents’ violence and otherwise non-constructive means of resolving interpersonal conflict, will have frequent opportunities to
observe, acquire, and produce similar behaviours in response to their own interpersonal problems.

In one of the studies dealing with social skills of children of battered women, Hinchey and Gavelek (1982) used Borke's (1971) Interpersonal Perception Test, to assess the empathic abilities of both children from violent families and non-violent homes. Thirty mothers and their pre-school children served as subjects. In the sample there were equal number of boys and girls. Half of the mothers had a history of having been abused by their husbands, while the other half came from non-violent homes. These researchers found that children from abusive homes showed a deficit in abilities associated with empathy compared to the control group, that is, they performed poorer than the control group on measures of role-enactment, on social-inference and role taking, but were not different on behavioural observations of social behaviour. The researchers suggested that this social deficit might inhibit the development of intimate relationship both now and in the future. They further proposed that future work be directed at examining the longitudinal effects of wife-abuse upon the child witnesses to marital violence.

In a similar study, Rosenberg (1984) studied the social-problem-solving abilities of a group of children who witnessed parental violence. The researcher found that children from violent homes who witnessed a relatively high level of violence differed from those who witnessed relatively less violence in two important ways: Firstly, they indicated lower performance on a sub-measure of interpersonal
sensitivity, which meant that they had greater difficulty in identifying the problem-situations and understanding the thoughts and feelings of these involved. Secondly, they tended to choose either passive or aggressive strategies to resolve interpersonal conflict and were less likely to choose assertive strategies.

In another study, Adamson and Thompson (1998) found that compared to a control group, children who witnessed family violence were more likely to suggest aggression as a coping strategy for conflict and were less likely to suggest direct problem solving. Children who use aggression to solve interpersonal problems tended to be sad and withdrawn and this impacted on the child’s participation in social activities. Research findings also indicated that children who witnessed family violence spend less time with friends and had poorer quality friendships than children who were not exposed to violence (Graham-Bermann, 1998).

2.3.5 Physical Health

In addition to behavioural and emotional effects, exposure to parental violence can impact on the physical health of children. For instance, infants exposed to violence can suffer from failure to thrive due to disruptions in developmentally critical behaviours (e.g. sleeping, eating, play/exploration (Sudermann & Jaffe, 1997). This places them at risk of death or serious brain impairment due to malnutrition. The physical health of toddlers and preschoolers who witness violence is also at risk. Research has documented health problems, poor sleeping habits, poor eating and weight gain, and somatic complaints in this population.
(Alessi & Hearn, 1984; Hilberman & Munson, 1977-78); Hughes, 1986; Sudermann & Jaffe, 1999). Somatic complaints have also been reported in school age and adolescent children (Alessi & Hearn, 1984; Hughes, 1986).

2.3.6 Long term problems

Most studies reviewed above so far have examined child problems associated with recent witnessing of domestic violence. A number of studies have mentioned much long-term problems reported retrospectively by adults or indicated in archival records (Edleson, 1999). For example, Silvern, Karyl, Waelde, Hodges, Starek, Heidt, and Min (1995) study of 550 undergraduate students found that witnessing violence, as a child was associated with adults' reports of depression, trauma-related symptoms, and low self-esteem among women and trauma related symptoms alone among men. Witnessing violence appeared to be independent of the variance accounted for by the existence of parental alcohol abuse and divorce. In the same vein, Henning, Leitenberg, Coffey, Turner and Bennet (1996) found that among 123 adults women who had witnessed domestic violence as a child greater distress and lower social adjustment existed when compared to 494 non-witnesses. These findings persisted even after accounting for the effects of witnessing parental verbal conflict, being abused as a child, and level of reported parental caring.
2.3.7 Inappropriate Coping Strategies

Research on the coping process of children witnessing family violence has received scant empirical attention thus far. It has only recently emerged as a topic of interest among child clinical and developmental theorists. Rossenberg and Rossman (1990) argued that understanding the child's coping with stress would provide an important direction for treatment programs.

For the purpose of this review, coping would be conceptualised as children's cognitive and behavioural efforts to manage external and internal events that are potentially harmful to them (Lazarus & Folkman, 1984). In the case of child witnesses, the external events may include the actual violence between the parents and the potential for the child to be physically injured during the violent incidents. Internal events may include management of overwhelming emotions such as fear, anxiety, confusion and anger during and after the violence. This is consistent with the theorizing of Grych and Fincham (1990, 1993) who conceptualised inter-parental violence as a stressor that leads to an attempt by the child to understand and cope with the conflict.

Pynoos and Eth (1986) conducted one of the first studies on children's coping strategies. In their study they interviewed 200 children who had witnessed extreme forms of family violence including homicide, suicide, rape, aggravated assault, accidental death and community violence. The format of the interview
proceeded from projective drawings and story-telling, to discussion of the actual traumatic situation and the perceptual impact, to issues centred on the aftermath and its consequences for the child.

The researchers found four common strategies used by the pre-adolescents to modulate their anxieties shortly after witnessing the traumatic events. In the first category, when children were asked to tell a story, some children reversed the violent outcome of their story and provided a more acceptable ending as a way of coping with their painful reality. The researchers referred to this strategy as "denial-in-fantasy". A second group inhibited spontaneous thought and avoided association with the traumatic event.

Those in the third group were unable to distance themselves from the trauma by engaging in fantasy and drew an actual scene of the event, accompanied by an emotional account of what occurred. A fourth group were described as being in a "constant state of anxious arousal". Their preoccupation with feelings of vulnerability and thoughts of future danger pre-empted discussions of the recent events.

In a study, Rosenberg and Rossman (1990) investigated children's coping strategies and their beliefs about control in a situation of parental violence and discord as they related to child outcome, 94 children mother pairs were interviewed. The children's ages ranged from 6 years to 13 years. A measure of the extent to which children witnessed marital violence and discord was obtained.
from interviews with their mothers. Children were asked to endorse their preferred coping strategies when feeling negative affect in general, without identifying the specific situations that elicit these feelings. The coping strategies included both problem-solving and emotion-focused items that constitute five subscales from the Child Perceived Coping Questionnaire (CPCQ) (Rosenberg & Rossman, 1990): use of parents, use of peers/self, Distraction/Avoidance, Emote and Self-soothe. The researchers found that children in the violent-home and discordant groups endorsed greater use of parents for coping with negative feelings than children in either the violent shelter or satisfactory groups. The researchers hypothesized that higher endorsement of parents might represent a more urgent attempt by children in these groups to gain parental attention, supported and reassurance.

2.4 FACTORS INFLUENCING THE DEGREE OF PROBLEMS ASSOCIATED WITH WITNESSING FAMILY VIOLENCE

According to Edleson (1999) there are several factors which appear to influence the degree to which a child is affected by witnessing parental violence. A number of these factors also seems to interact with each other creating unique outcomes for different children. Therefore, for intervention to be successful, it is imperative for the clinicians to take these factors into consideration when planning an intervention program.
2.4.1 Abused and witnessing children

Hughes, Parkinson and Vargo (1989) have suggested that both witnessing abuse and also being abused is a “double whammy” for children. Their study compared children who were both abused and had witnessed violence and to others who had been exposed to neither type of violence. They found that children who were both abused and witnesses manifested the most behavioural problems, while those who witnessed violence only showed moderate behavioural problems and the comparison group were the least in terms of behaviour problems. These findings were echoed by McCloskey, Figueredo and Koss’s (1995) study in which it was found that the experience of being abused or both abused and a witness is more negative than witnessing adult domestic violence alone.

The combination of being abused and witnessing violence appears to be associated with more serious problems for children than witnessing violence alone.

2.4.2 Child characteristics

The majority of findings point to different factors for boys and girls associated with witnessing violence. In general, boys have been shown to manifest more frequent problems and ones that are categorized as external, such as hostility and aggression, while girls generally show evidence of more internalised problems,
such as depression and somatic complaints (Carlson, 1991; Stagg, Wills & Howel, 1989). There are also findings that dissent from this general trend by showing that girls, especially as they get older, also exhibit more aggressive behaviours (Spaccarelli, Coatsworth & Bowden, 1995).

Children of different ages also appear to manifest different responses associated with witnessing violence. Children in preschool were reported by mothers to exhibit more problems than other age groups (Hughes, 1988).

Edleson (1999) found that few studies reported differences based on race and ethnicity. O'Keefe's (1994) study of White, Latino, and African-American families of battered women found that all the children were viewed by their mothers as having serious emotional and behavioural problems. The only difference found between the groups was on social competence; African-American mothers rated their children more competent when compared to other mothers' ratings of their own children.

2.4.3 Time since occurence of violent event

According to Edleson (1999), the longer the period of time since exposure to a violent event the fewer the effects a child experiences.
This view is supported by Wolfe et al., (1985) who in their study found that more social problems among children residing in shelters than among children who had at one time in the past been resident in a shelter.

2.4.4 Parent-Child relationship factors

A number of authors have discussed a child’s relationship to adult males in the home a key factor. Peled (1997) suggests that children’s relationships with their battering fathers were confusing, with children expressing both affection for their fathers and resentment, pain and disappointment over his violent behaviour. Children’s relationships with their mothers have also been identified as a key factor in how children are affected by witnessing domestic violence (Edleson, 1999). Some have suggested that a mother’s mental health would negatively affect a child’s experience of violence. For example, Wolfe et al., (1985) in their study found that maternal stress statistically accounted for a large amount of child behaviour problems. McClosky et al., (1995) however, in their study found that mothers’ mental health did not affect a child’s response to domestic violence.

2.4.5 Family support and children’s perceptions of their parental relationships

This has also been identified as a key factor in parent-child variables. For example, Durant, Cadenhead, Pendergrast, Slavens and Linder (1994) found home environment to be important among the 225 urban black adolescents they
studied. Adolescents exposed to community and domestic violence appeared to cope better if they lived in more stable and socially connected households.

2.5 THERAPEUTIC PROGRAMMES TO ASSIST CHILDREN'S WITNESS TO FAMILY VIOLENCE

When discussing interventions with children exposed to domestic violence, Jaffe, Wolfe and Wilson (1990) often talk of ‘preventing further harm’ or ‘reducing the negative impact of the trauma.’ This form of intervention is sometimes referred to as “tertiary prevention” in community psychology. When intervening with children exposed to domestic violence, tertiary prevention involves working with children who are already experiencing social, emotional, or behavioural problems as a result of living with a batterer (Schewe, 2004). In community psychology practice, examples of tertiary interventions include individual or small group counselling for children of abused women who have been referred for counselling by a school for emotional or behaviour problems. Other forms of intervention include “secondary prevention” and “primary prevention”. Secondary prevention involves working with high risk children who have been exposed to domestic violence but have yet to display negative social, emotional, or behavioural consequences.

One example of a secondary intervention would be group therapy for all children accommodated in a domestic violence shelter, regardless of symptoms of exposure to trauma.
2.6 GROUP THERAPY AS TREATMENT APPROACH

Group work with children who witnessed family violence is well documented (Peled & Davis, 1995; Rosenberg & Rossman, 1990; Suddermann & Jaffe, 1997;). In fact a group intervention is even more supported in the literature than individual intervention (Hage, 2000; Groves, 1999). In a local community psychology project, group therapy is conceptualised as a social action program (e.g. the Mandeni project mentioned in Edwards, 1999). The group setting provides victims with the most needed assurance that they are “normal” in the context of the group. Further it breaks the secrecy and isolation of the individual child, thus fostering solidarity (Hagan & Smail, 1997b). Hage (2000) illustrates how a community psychologist, who uses the community group counselling model, can effectively provide out-reach services to these at-risk group of children. He even termed them “forgotten” victims of family violence.

2.6.1 Advantages of Group Therapy

Group work with children who witnessed family violence is well documented (Peled & Davis, 1995; Rosenberg & Rossman, 1990; Suddermann & Jaffe, 1997). According to these researchers the most effective way to help children who witnessed family violence to express their feelings is in a group setting instead of an individual setting. The group setting provides victims (children) with the most needed assurance that they are “normal” in the context of the group. It further
breaks secrecy and isolation of the individual child and enables children to tell their stories in the presence of others who closely identify with the experience this fostering solidarity (Hagan & Smail, 1997b). The benefits of group therapy have further eloquently been delineated by Yalom (1985). The most curative factors relevant to victims of child witness to family violence are those of universality, interpersonal learning, identification, altruism, self understanding and the instillation of hope. It is a powerful experience for the victim to learn that she is not alone with the “secret” of family violence.

The establishment of relationship with others in the similar situation provides a normative context within which they can ventilate their feelings, fears, anger, sadness and the sense of isolation they have experienced. They also get a chance to share and learn more effective methods of coping and conflict resolution strategies. Once the individual victim is introduced into the group and the group is functioning as a victim with some of the most sensitive and delicate areas of the problem.

In a local community psychology project, group therapy is conceptualised as a social action programme (e.g. the Mandeni project mentioned in Edwards, 1999). Hage (2000) illustrates how community group counselling model can effectively provide out-reach services to these at risk group of children.

Primary prevention involves working to prevent children's exposure to domestic violence in the first place. According to Carlson (1984), “intervention with the
children may, in essence, constitute the best form of primary prevention of adult domestic violence" (p.160). The present researcher focuses primarily on secondary and tertiary interventions for the children exposed to domestic violence.

2.6.1.1 Providing information and building group cohesion

Many of the interventions provided to children were conducted in small groups, early sessions often consisted of providing information about the group, setting up group rules, and generally getting to know one another (Grusznski, Brink, & Edleson, 1988; Peled & Edleson, 1992). Information such as the purpose of the group, length and duration of the group, and definitions of various types of violence are often provided.

Ground rules for the group are often developed by facilitated discussion within the group (Graham-Bermann, 2000). Common ground rules address issues such as use of violent words or actions, the ability to not speak or pass your turn to speak, interrupting others when they are speaking, and confidentiality (and the limitations of confidentiality in cases of child abuse).

2.6.1.2 “Breaking the silence”

A primary goal of many therapeutic interventions is to promote open discussion of the children’s experiences. Although some may feel that it is best if a child does
not dwell on disturbing events, the process of retelling or re-enacting a traumatic event in the safety of a therapeutic relationship can be in itself a healing experience (Groves, 1999; Peled & Edleson, 1992; Wilson, Cameron, Jaffe & Wolfe, 1989; Wolak & Finkelhor, 1998). Speaking openly with others about violent events can also serve to reduce the sense of shame and isolation suffered by many children of abused women. Another approach used to counteract a child’s hesitation to disclose his/her experiences is to encourage the parent(s) to give the child verbal permission to talk about the family before the individual counselling or small group starts (Wilson et al., 1989).

2.6.1.3 Dealing with feelings of responsibility for violence in the family

In the course of discussing the traumatic events, it is important to help children understand why their parents fight, and more importantly to realize that the fighting is not the child’s fault (Graham-Bermann, 2000; Groves, 1999; Peled & Edleson, 1992; Wolak & Finkelhor, 1998). Children should be helped to understand that parental actions are adult issues, and not the responsibility of the children. Children should be dissuaded from the belief that they can change their parents’ violent behaviour (Schewe, 2004). Interventions that focus on this issue include discussions of parents’ use of violence and emotional, verbal, alcohol and drug abuse, with the emphasis that each person is responsible for his/her own actions. Children may be encouraged to write stories related to actual violent incidents, and then to identify the individuals responsible for
specific behaviours. These stories can be read to the group or acted out (Grusznski, Brink & Edleson, 1988; Wilson et al., 1989).

2.6.1.4 Identifying feelings

An important objective of many interventions for children of abused women is to provide children with a better means of expressing themselves (Peled & Edleson, 1995). Learning to identify and label feelings not only helps children to express themselves to others, but may also help them better understand their reaction to fighting between their parents. Group facilitators will commonly ask children to identify different feelings, and describe situations when they might feel that way. Others use vignettes to facilitate discussion. For example, a vignette might read: “your two best friends go to someone’s house to play without you. How do you feel?” Older children might be encouraged to rate the intensity of their feelings on a ten-point scale (Wilson et al., 1989).

Given that many children from violent homes have found that it is dangerous to express their feelings, learning when it is and is not safe to express feelings might also be important (Grusznski et al., 1988).

Grusznski et al., (1988) described a variety of techniques and activities that can help children of all ages to better identify and express feelings.
2.6.1.5 Dealing with one's own anger

Teaching children to effectively manage anger is an important step in breaking the intergenerational cycle of violence (Schewe, 2004). Developing relaxation skills is a common anger control strategy. Another strategy is to have groups of children brainstorming healthy and unhealthy ways of dealing with anger. Children can then be encouraged to makeup conflict scenarios involving peers, siblings, parents, or teachers and then role-play non-violent methods for handling the conflict (Wilson et al., 1989). Jouriles, McDonald, Stehpens, Norwood, Spiller and Ware (1998) worked with the mother and child together with the goal of reducing aggressive behaviour. In these sessions the mother and child document aggressive behaviours, discuss strategies that they have used to address these behaviours, and explore new behaviourally-based. Modelling non-aggressive, rewarding and reinforcing non-aggressive solutions, and implementing consistent and appropriate parental responses to aggression are all part of the treatment programme (Jouriles et al., 1998).

2.6.1.6 Identifying/using social supports

Social support interventions often focus on the positive aspects of the children's current social support system and provide them with resources for maintaining or enlarging this network (Wilson et al., 1989). Previous social support that the children have use is discussed, with attention to which one's were most helpful. Local community resources for various problems are identified and discussed.
The children are encouraged to identify a support system that could be used if they are upset or have suicidal feelings. Some of the fears that the children may have had about telling someone about their problems can be discussed, including reasons why some families keep fighting a secret (Wilson et al., 1989).

2.6.1.7 Self-concept and self-confidence

In Wilson, Cameron et al., (1989) 10 session intervention for 8 to 13 years – olds exposed to domestic violence, one 90 minute session is devoted exclusively to exploring children’s self-concept and boosting confidence. The sessions are 1. to help children understand how they perceive themselves, both as individuals and in relation to others, 2. To help children relate their self-perceptions directly to their experiences with their parent and to identify similarities and differences between themselves and their parents, and 3. To help boost the children’s self confidence. Children are encouraged to identify when they feel positively and when they feel negative about themselves.

Time is spent discussing the situations that surround each of these self-perceptions. Making a “life puzzle” helps children perceive their experiences of themselves in different environments. The life puzzle involves giving each child a piece of construction paper that is then cut into four puzzles shapes that are fitted together to illustrate the child as a whole person. Each puzzle piece represents a different area of the child’s life, such as when he/she is at school or with his/her family, peers, or group. The children discuss how they perceive themselves and
how others perceive them in these situations. Further discussion allows children to explore the similarities and differences between themselves and their parents. The session ends with the children divided into pairs where each child tells the other what he/she likes about the other person (Wilson et al., 1989). Grusznski et al., (1988) describe an esteem-building activity where group members create two collages, one that include words or pictures that represent how others see them, and one that represents how they view themselves.

When children are asked to represent their collages, other group members will often times reinforce and add to the positive attributes presented and refute the negative ones. A positive group experience usually translates into a positive experience of themselves and their capacity to be respected and cared for (Peled & Edleson, 1992).

2.6.1.8 Learning about the cycle of violence and the dynamics of family violence

Understanding the cycle of violence and debunking the myths that surround family violence are common goals for interventions with children of family violent homes. Children's concerns that violence is inevitable in their own lives are addressed.

Furthermore, misconceptions around spouse abuse for example, that all batterers are mentally ill, can be discussed and accurate information provided. Discussing
the cycle of violence and reasons for separating or staying with one's partner can further children's understanding of the dynamics of family violence (Wilson et al., 1989).

2.6.1.9 Conflict resolution/problem solving/communication skills

With older children, groups might discuss violence in personal relationships, and address anger management and the use of conflict-resolution skills within these relationships (Groves, 1999). Children from violent homes often lack healthy models of adult relationships. Teaching and modelling assertive (as oppose to aggressive) communication skills, problem solving skill, and other healthy relationship skill, are an important step in the process of breaking the cycle of violence (Graham-Bermann, 2000; Peled & Edleson, 1992).

In conflict situations, Grusznski et al., (1988) advocate altering one's goal from forcing a change or expecting agreement to understanding the other person's position. Seeking understanding rather than forcing change is often a novel idea for group members, and helping children understand the difference between these goals is very important.

2.6.1.10 Symptoms reduction

In addition to needing emotional support, increased coping and safety skills, and preventive interventions, many children exposed to domestic violence will also
need relief from specific symptoms that result from exposure to violence such as insomnia, nightmares, depression, anxiety, and other post-traumatic (PTSD) symptoms.

For example, if a child is suffering from insomnia and nightmares, practitioner might work with the parents and child to build soothing and comforting bedtime routine or refer for pharmacological management (Schewe, 2004).

2.6.1.11 Increasing safety and stability

Child advocates and counsellors help the families create safe, stable, and nurturing environments for their children. It is difficult for children to recover from the effects of exposure to violence if the violence persists (Groves, 1999). In situations where children continue to live in dangerous environments, practitioners strive to help the non-abusive parent obtain safety for herself and her children. In accomplishing this task, the advocate must often help the family address additional stressors, such as substance abuse or housing difficulties.

In situations where the children and mother are not living with the batterer, therapeutic interventions aim to promote the children's feelings of safety and security. Counsellors work with parents to help them understand the children's need for consistent routines.
With parental permission, treatment may also include consultation with teachers or child care providers in order to develop consistent strategies for supporting the child's development (Groves, 1999).

Typical small group interventions with children include problem solving various ways to handle "unsafe" situations and identifying or role-playing ways to stay safe while parents are fighting (i.e. going to neighbours, calling the police) (Grusznski, et al., 1988; Peled & Edleson, 1992; Wilson et al., 1989).

2.6.1.12 Dealing with repeated separation

As counsellors approach the end of any small group or therapeutic relationship, some preparation for termination is important. When working with children likely to have experienced numerous separations from both family and friends, this preparation is critical (Wilson et al., 1989). Discussing separation from the therapeutic relationship can often lead to discussions about other separations in the children's lives. When discussing marital separation, issues that children often raise include limitations or imposition of access time with the non-custodial parent, new partners in their parents' lives, being used as a messenger between the parents, conflicting loyalties to parents, ambivalence about parents and wishes that their family were together again (Wilson et al., 1989). Such discussions can be facilitated by having the children draw pictures of their family in the past, present, and future. Films on divorce and separation are also useful. Children can be encouraged to explore strategies among themselves that might
enable them to facilitate the positive aspects of their relationship with their parents or come to terms with ongoing and inevitable difficulties. Advantages and disadvantages of living in a stable single-parent family compared to a violent two-parent family can be discussed.

As the end of the therapeutic relationship draws closer, children can be encouraged to reflect on how they felt at the beginning of the new and unfamiliar group compared to how they feel at the end of the group with new friends and new experiences.

This discussion can help alleviate children's fear of new and unfamiliar situations in the future (Wilson et al., 1989). The skills and strategies that they have learned to empower and protect themselves should be reviewed. Having the children discuss what they have learned from and like about one another is also helpful. Discussing how the children have dealt with other separations and stresses in their lives and encouraging them to focus on the positive aspects of their experiences and relationships help terminate the group on a positive note (Wilson et al., 1989).

### 2.6.2 Effectiveness of Group Therapy Programmes on child witness to family violence

Although carefully controlled outcome studies examining the effectiveness of interventions for children who have witnessed domestic violence do not yet exist,
there is some preliminary evidence that these services are fruitful. One of the first treatment groups for children of battered women was developed by Hughes (1982).

This program served children and their mothers living in battered women's shelters and was aimed at fostering parenting skills, building children's self-esteem, reducing anxiety, and improving coping behaviours along with altering attitudes toward family violence. Both individual and group modalities were offered. The educational aspects of the program relied on the principles of cognitive theory in assisting children in the development of new ways of thinking about families, of understanding the unacceptability of violence, and about new ways of solving interpersonal problems. Cognitive-behavioural therapies focused on reframing the child's understanding by adding new information and changing existing cognitive scripts. Evaluation of this group treatment was undertaken by Hughes and Barad (1983).

Questionnaires measuring self-esteem, 12 children completed anxiety and attitudes toward domestic violence both before and after their shelter stay. Mothers completed the parent version of the Child Behavior Checklist (Achenbach & Edelbrock, 1982).

While differences were not found in children's problem behaviours, the mothers did not report less anxiety, as a result of their child's participation in the program. Another interesting program was designed by Frey-Angel (1989) to
address concerns of 3-7 year old children exposed to family violence and their old siblings. Here siblings’ pairs were seen in a group setting. The goals of the groups were to learn new coping skills, alternatives to violence, non-violent emotional expression, and to stop the intergenerational transmission of violence. However, only clinical case examples are provided on outcomes with the report that positive changes in behaviour were seen.

In another study, Jaffe et al., (1989) conducted interviews with children and their mothers before and after they participated in a 10-week small group intervention that addressed many of the topics already addressed. The mothers who were interviewed indicated that their children enjoyed the group (93%), learned something from the group (62%), and changed their behaviour as a result of the group (33%). Interviews with the children indicated that, after the group, more children could identify three or more appropriate reactions to emergency situations (44% pre-intervention vs. 73% post), more could identify two or more positive things about themselves (53% pre vs. 85% post), and fewer condoned violence in their families.

A subsequent evaluation of the Jaffe et al., (1989) program found improved attitudes about violence, increased coping skills, and improved anger management, but no change in safety skills. An informal follow-up at 6 months indicated that children and their parents were able to give concrete examples of sustained changes in both attitudes and responses to anger (Wagar & Rodway, 1995).
A ten-session, weekly program designed to teach problem-solving conflict resolution, and safety skills to 5-7 year old children of battered women was evaluated by Tutty and Waggar (1994). Based on the assumption that the children learned the responses of either aggression or withdrawal from their parents, they were considered to be at risk of becoming either perpetrators or victims of violence; program goals ranged from the general to the specific and included:

(a) cutting short the intergenerational transmission of violence (b) teaching alternative problem-solving practices, (c) developing safety skills, and (d) challenging Tutty and Waggar (1994) reported that the program was deemed helpful by parents and the children, but give only anecdotal evidence of its success. Attrition rates were reported as more than half, many children had irregular attendance, and only a few parents entered a concurrent support group. There was no follow-up evaluation.

Sudermann, Marshall, Loosely (2000) evaluated an updated version of the group treatment, which was named Community Group Treatment Programme for children Exposed to Woman Abuse. Although the sample size was small (31 children aged 7 to 15 years) they found a variety of positive effects the children’s attitudes and beliefs about women abuse and other forms of violence. Knowledge of community resources and non-violent conflict resolution also improved.
Both children and parents were very satisfied with the group and positive changes were noted in the majority of cases. Peled and Edleson (1992) demonstrated that their 10-session group programme met many goals, including breaking the secret of violence, enhancing self-protection skills, and increasing self-esteem. This research was qualitative in nature in an attempt to avoid obtrusive assessment measures and in keeping with the non-specific goals of the group. Ragg, Sultana, and Miller (1998) developed and evaluated a group programme which had the goals of providing social support and increasing the social skills of child witness to family violence. The results demonstrated a significant decrease in behaviour problems following group participation. Most recently, Pepler, Catallo, and Moore (2000) assessed a peer group-counselling programme. This programme used discussion, role-playing, and games to cover a variety of topics relevant to the child witness to domestic violence.

The pre-post design revealed no significant changes in children's attitudes towards violence, likely due to the fact that the children had generally appropriate attitudes at the outset of the group.

Importantly, the children's anxiety and depressive symptoms improved across the course of the group, as did their behaviour problems. Mother's involvement in a concurrent support group did not impact on the children's outcomes.
Unfortunately, no control group was included in this study, which makes it impossible to conclude that the observed changes were due to the impact of the group and not the passage of time.

The efficacy of a broad-based advocacy programme was assessed by Sullivan and Davids (1998). Services to the children included a mentoring relationship with college students and a 10-week support and psycho educational group. In addition, mothers and children received advocacy support and weekly contact with a paraprofessional. A control group and an 8-month follow-up period were included in the design. The results showed positive impact on maternal functioning but no changes in children's problem behaviours at home or school.

Graham-Bermann (2000) also discusses an extensive evaluation that she conducted on the preventative intervention programme that she developed for child witness to domestic violence and their mothers. “The kids club” involved a ten-week group for children as well as a concurrent parenting programme. Participants were randomly assigned to a waitlist control group, a child-plus-mother intervention group, or a child-only-group.

The child-only-group attended the ten-week children's group while the children in the child-plus-mother group had mothers who also received parenting training.
Post-treatment assessment revealed significant changes in the cognitive, social, and emotional behavioural functioning among the children (Graham-Bermann, 2000). Both treatment group showed improved knowledge of family violence, reduced self blame, enhanced coping, and improved knowledge of conflict resolution. Positive changes in social and emotional functioning were also observed in the treatment groups. However, levels of anger increased, which Graham-Bermann, (2000) attributes to the children becoming more aware of their feelings related to family violence. In contrast to the secondary level programmes discussed above, there are few programs for child Witness to Family Violence that target children with a specific level of specific symptoms.

Therefore, few existing programs can be defined as tertiary prevention (Graham-Bermann, 2000). One study by Jouriles et al., (1998) looked at a program targeted at Child Witness to Family Violence who had developed serious behavioural problems.

Unlike most of other programs discussed here, interventions focused primarily on the parenting ability of the mother, although children were provided with a mentor. Families were randomly assigned to a treatment or no treatment group. Preliminary results from a small number of families appear to indicate a reduction in child externalising problems and enhanced parenting skills in the treatment condition as compared to the no treatment condition as compared to the no treatment control. These differences were maintained at the 8-month post-treatment follow-up.
2.7 THE BENEFITS OF EARLY INTERVENTION WITH CHILDREN EXPOSED TO INTIMATE PARTNER VIOLENCE

Negative consequences of exposure to violence have been well documented (Osofsky, 1995; Govender & Killian, 2001, Seedat, Nyamai, Njenga, Vythilingum & Stein, 2004). However, little attention has been paid to resilience of children exposed to intimate partner violence. As explained by Rutter (2006) resilience refers to resistance to environmental risk experiences, or the overcoming of stress or adversity.

Knitzer (2000) and Osofsky (2004) state that young children are resilient and have a capacity for recovery. Research findings (Shonkoff and Phillips 2000) show that the developing brain has a tremendous degree of plasticity and is largely shaped by early experiences. Thus, if we can intervene early and provide positive experiences for young children exposed to intimate partner violence, we can strengthen their resilience. It seems essential that interventions helping to heal young children exposed to violence focus on building resilience.

2.8 CONCLUSION

The literature reviewed in this chapter indicates that parental violence is likely to affect all witnessing children, in some way either in the present or in the future, or both.
Therapeutic work with emphasis on group interventions on the child witness to domestic violence was outlined.

The next chapter deals with the research methodology for this study.
CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

When collecting data for a study it is the researcher's responsibility to choose a suitable method to gather information. This chapter describes the research design and methodology used by the researcher to collect data. Neuman (2003); Mouton (2001); Rubin & Babie (2001) and Huysamen (1994) all refer to research design as a plan of how a researcher intends conducting the research/plan according to which data are collected to investigate the research question. In support of this notion Kerlinger (1986) describes a research design as a research programme.

3.2 THE STUDY

3.2.1 The Objectives of the study

The objectives of this study were:

- to tap the experiences of children who witnessed spousal violence and
- to establish a therapeutic group for children who witnessed spousal violence and evaluate its effectiveness.
3.2.2 Hypotheses

Group therapy will:

- decrease emotional, social, behavioural and cognitive problems of children who witnessed spousal violence.
- Improve quality of life of children who witnessed spousal violence.
- Lead to positive appraisal by mothers, of children in respect of children's learning, handling of conflict and use of appropriate conflict resolution skills.

3.2.3 Research Technique

The evaluation research method, which is a specific form of social research that concerns itself with systematic acquisition and assessment of information, to provide useful feedback about some object, was appropriate for this study. In support of this notion, Chemane (2004) notes that evaluation research gives scientific information regarding service provision or programs.

In using the evaluation method the researcher's interest was on the end product of the investigation and not on the development of a theory. A major advantage of evaluation research is that it ties research with theory. Evaluation research which
is action-oriented, is a highly recommended research approach in the field of Community Psychology (Chemane, 2004).

The subject of investigation was researched using both quantitative and qualitative approaches. This means that some information from the subjects was in a form of numbers and other data was in a text form. According to Chemane (2004) using both approaches at the same time is advantageous since these approaches complement each other.

3.2.4 Sampling Method

A non-probability, convenience and purposive sampling method was chosen for this study. Trochim (2006) considers:

- non-probability sampling as meaning that sampling does not involve random selection as it was the case in the present study. This implies that not all individuals of a population will enjoy the same probability of being selected and thus the representativeness of the sample cannot be assured;
- convenience sampling as, meaning that researchers use participants who are available to them as their samples;
- purposive sampling as, meaning that the problem is approached with a specific plan in mind. Here, data was collected from information rich participants about the phenomena under investigation (Ary & Razavich, 1996, Bailey, 1996). In the present study, the group under investigation
that would provide information was children who witnessed spousal abuse. In purposive sampling we sample with a purpose in mind, because we had a specific predefined group that we sought. Purposive sampling is useful because one is able to reach a targeted sample quickly and as a researcher you are more likely to obtain the opinions of the target population.

3.2.5 The participants

3.2.5.1 A group of 12 children (six males and six females) who witnessed family violence participated in the study. The criteria for inclusion in the study was that:

- Children are between the ages of 8-13 years;
- Children do not have known psychopathology;
- Children have recently witnessed (seen or heard) family violence;
- Children will not receive individual therapy during the time of the group program;
- Children should display willingness to talk about their experiences in a group setting;
- Children must be verbally fluent and able to communicate their feelings, thoughts and perceptions in relation to family violence;
• Children should be South Sotho speaking, the home language of the researcher to obviate the possibility of losing subtle semantic nuances happening when translation is done (Levy, 1973). Ndlovu (2001) in his group work with sexually abused children, notes the ease with which the group runs if there is no translation done, and if the researcher and the subjects speaks the same language.

The present researcher considered that using a group of 12 children who have witnessed family violence would suffice as the nature of this study requires quality of information, and not the frequency with which it occurs from subject to subject, (Koning, 1979). The average age of participants was 12.5 years. Of these children 50% were girls and 50% were boys. A fair representation of the sample in terms of gender was achieved. All children were Africans and South Sotho speaking, the language of the researcher.

3.2.5.2 Twelve (12) mothers of the twelve (12) children who formed the therapy group participated in the study.

3.2.6 Research Instrument

To capture the dual nature (quantitative and qualitative) of the study a questionnaire consisting of closed and semi-open ended questions seemed to be the best instrument to use for investigation. The advantages of this instrument
are that it is cost effective, not labour intensive and it can collect volumes of data within a limited period. The choice of a questionnaire was also based on the fact that it would create a non-threatening and relaxed interviewing atmosphere. Questions on the questionnaire were in the participants' mother tongue (Southern Sotho) to avoid misunderstandings.

3.2.7 Ethical Consideration

Confidentiality was taken care of. Participants in the study were assured that data collected from them would be kept safe and would not be disclosed to the public. To comply with this ethical consideration for conducting research in behavioural sciences, the researcher took the precaution to ensure anonymity of participants by not including their names on the questionnaire. Participants were informed that their responses would only be released when permission is given by them.

The question of confidentiality is of particular importance in families such as these. For both mothers and children there is an equal risk of harm by the fathers. The term "father" in this study refers to the person who abused the child's mother. This includes biological fathers, stepfathers and mothers' male partners or companions.

The researcher also considered the disclosure issue of child-provided information to the mother. On the one hand, mothers have all parental rights to hear what their children are doing, and, indeed children might be comforted by their
mother's proximity. But on the other hand, children might not disclose as freely as they would like to in the presence of their mothers. In addressing this ethical dilemma, mothers were given the choice of remaining in the room while children were being interviewed.

3.2.8 Procedure

Informed consent was obtained from participants prior to briefing and data collection. (See appendix A). The purpose of the study was explained to participants.

To minimize confusion or misunderstanding participants were briefed on how to go about with answering the questions on the questionnaire.

All interviews with children and their mothers were conducted by the researcher himself, as it was felt that this was the best method of obtaining information. Data collection included interviews with 12 mothers and 12 children who had participated in the group therapy programme. Ten (10) group sessions and two (2) sessions with mothers were undertaken. Interviews were conducted by the researcher using the questionnaires specifically developed for this study. (See Appendices B, C, D, E).

The researcher also concerned himself with observations during group sessions. The resulting data consisted of 12 interviews and notes on observed sessions.
Interviewing young children on an emotionally loaded subject was one of the challenges of this research project. Several design factors were considered to maximize the safety for the child and to promote his/her willingness to share thoughts and feelings about the group. Voluntary participation was stressed to each child and parent throughout the interviews. The interviews were conducted as a relaxed conversation. The researcher conducted the pre-group therapy interviews, administered the questionnaire to children (see Appendix C) and facilitated the group formation.

The researcher also interviewed all the parents of children (see Appendix B). These interviews took place two weeks prior to group therapy commencement with children and were also repeated after the last session of group therapy (that is, pre-and-post program interviews) were done.

The group therapy programme was initiated with children and it was hypothesized that the group intervention would make positive impact on the children’s coping abilities. The programme evaluation was, therefore, seeking to find out whether these children would actually benefit from the programme.

Programme evaluation by participants has its advantage. According to Magwaza and Edwards (1991) the person who receives the service is in the excellent position to evaluate different aspects of the programme, as he/she is the only one who has access to his/her feelings. Since the program is specifically designed for
these particular participants, they are, therefore, the best people to assess whether it met their needs or not.

In order to meet the commitment of developing and implementing the evaluation of group therapy in ways that would generate real confidence in the findings, it was decided that the effect of the group service would be evaluated from multiple perspectives: those of the children who participated and those of their mothers. For this purpose pre and post test evaluations were undertaken in an attempt to determine whether and how the emotional condition and coping capabilities of children have changed from the beginning of the group experience to its conclusion.

The decision to undertake this kind of multi-faceted evaluation meant that a significant amount of time would have to be dedicated to administration of the study instruments. Despite the burdens created by this approach, the researcher remained true to his commitment to a high quality evaluation and the results, as summarized in the next chapter, demonstrate the value of this endeavour.

3.2.9 Reliability and validity consideration

Validity implies that the instrument measures what it aims to measure (Kerlinger, 1986). Lofland (1971) argued that the validity of findings in qualitative research is not really possible. The argument that this author brings to our awareness is that even though qualitative methods have been well formulated,
there are few guidelines ensuring valid conclusions. Hence in this study both quantitative and qualitative approaches were used. The standard definition of reliability says the research instrument must produce consistent results on repeated use. Krippendorf (1980) argued that in qualitative research, the researcher him/herself is partly the research instrument; therefore the consistency of results depends on his/her skills as a researcher. From the action research perspective, it can be argued that the qualitative approach is objective, as both the researcher and the subjects negotiate the methodology, aims and objectives. Rather than validity and reliability, qualitative research is concerned with the integrity and credibility of the researcher in the authentic relation with co-researchers for faithful description, explication and interpretation of data (Krippendorf, 1980).

In this study Lincoln and Guba’s (1985) model is used to ensure the trustworthiness of the study. They identified four strategies for ensuring trustworthiness, namely, credibility, transferability, dependability and conformability. Credibility establishes how confident the researcher is with the truth of the findings. Data was collected from different sources namely, mothers and children and diverse methods were used to collect the data to ensure credibility (Sherman & Webb, 1988; Smith, 1987). Transferability was ensured through the use of a purposively selected sample so as to allow other researchers to make similar studies for purposes of comparisons (Krefting, 1990). Dependability, that is, the consistency of the findings (Krefting, 1990), was achieved through peer examination of the data. Two clinical psychologists were
requested to conduct an independent analysis of data collected. The researcher and these two independent coders met to reach consensus on the findings.

Confirmability was obtained through the use of saturation during data analysis. Responses were identified by their repetitive nature so that the researcher's biases did not interfere with the findings.

3.2.10 Scoring

Data collected was scored by the researcher. Information on scoring is reported in Chapter 4.

3.2.11 Data Analysis

To make sense of data collected frequencies of responses were tabulated for the total sample.

3.2.12 Conclusion

This chapter has mapped out the methodology adopted for the study. Validity and reliability of choosing this methodology has been argued for and ethical considerations have also been discussed.
The next chapter presents and analyses the data from pre- and post- evaluation questionnaire.
CHAPTER 4

DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1 INTRODUCTION
Completing data collection is not the final step in research. As noted by Makunga (1988) raw data are meaningless by themselves. With the data collected the researcher needs to make sense of it. This chapter, therefore, attempts to provide answers to research questions using the collected data. To analyse research material consisting of responses obtained by questionnaires simple descriptive statistical techniques were used. Frequency distribution tables showing the frequency of participants responses to questions were drawn and presented with comments and significant findings. This information is presented in two parts namely Part A analysis of biographical information and part B: analysis of pre-test and post-test responses.

PART A

4.2 BIOGRAPHICAL INFORMATION OF PARTICIPANTS
Table 1. Distribution of Children by gender and age

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>%</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>8–9 years</td>
</tr>
<tr>
<td>Females</td>
<td>6</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>Males</td>
<td>6</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

76
In the present study participants were equally distributed by gender, males N=6 and females N=6. This provided a fair presentation of both sexes and an opportunity to explore views across both sexes. According to Table 1 the majority of children 50% fell within the age range of 12-13 years, followed by the age range of 8-9 years at 34%. Few children, that is, 16% fell within the age range of 10-11 years.

Table 2. Population Group And Educational Level Of Children

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>%</th>
<th>Educational Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grade 1-3</td>
</tr>
<tr>
<td>Africans</td>
<td>12</td>
<td>100</td>
<td>2</td>
</tr>
<tr>
<td>Asians</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Whites</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 describes the distribution of children by population group and educational level. It was found that the sample was constituted by African children. There were no other race groups in the sample. One major contributing factor here was that the sample is from a shelter of abused victims (as indicated on p.5 of the present study) which accommodates Africans only. There percentage of children identified as in Grade 1-3 was 17%, those in grade 4-6,
33% and those in Grade 7-9, 50%. It is clear that in the sample there were less children in Grades 1-3 than in Grades 4-6 and 7-9.

**Table 3. Distribution of Mothers by Population Group and Age.**

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>%</th>
<th>Age</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africans</td>
<td>12</td>
<td>100</td>
<td>20-29</td>
<td>5</td>
<td>42</td>
<td>7</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30-39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40-49</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asians</td>
<td>0</td>
<td>0</td>
<td>20-29</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30-39</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40-49</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Whites</td>
<td>0</td>
<td>0</td>
<td>20-29</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30-39</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40-49</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>20-29</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30-39</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40-49</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>100</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

In the present study African mothers formed the sample. As can be seen the majority of mothers (58%) fell in the 30-39 age range and relatively less mothers (42%) fell in the 20-29 age range. No mothers fell in the 40 and above age range. This still provided a fair amount of age distribution for the present study.

**Table 4. Distribution of Mothers by Educational Level**

<table>
<thead>
<tr>
<th>Education level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1-7</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Grade 8-12</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>Tertiary qualification</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

It is clear from Table 4 that the majority of the mothers had secondary education (58%) followed by those with tertiary education (25%). Only 17% of mothers had education below the secondary level. This pattern dispels Pinto's (1981) notion
that marital violence is the problem of the poor and lowly educated and concurs with Padayachee (1988) and Mamphekgo (1994) who both respectively found that the highest frequency of abuse occurred amongst women with a secondary education followed by those with tertiary education.

Table 5: Occupation of the mothers

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housewife</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>Domestic</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Labourer</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Professional</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 5 indicates that the majority of women in this study (42%) were professionals, 24% were housewives, domestic workers and labourers were 17% each. These findings support Lawrence (1984) and Padayachee (1988) findings and is contrary to Naidoo (1992) who found that the majority of abused women were housewives.

Table 6: Other people living with the family

<table>
<thead>
<tr>
<th>Number of people</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>1-3</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>4-5</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
This question referred to how many other people besides the couple and their children were living at home. This gives an indication as to the size of the household, which gives some indication of the contributing or buffer effect of other family members to the family violence. It is evident that the majority of subjects (58%) were staying as a nuclear family followed by families where 1 to 3 other members were staying at home.

Table 7. Period of marriage

<table>
<thead>
<tr>
<th>Period (years)</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>6-10</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>11-15</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

Most of the women (42%) were married for 6 to 10 years followed by 1-5 years (33%). This indicates that there was a fair composition of subjects across the number of years in marriage.

Table 8. Period of onset of abuse in the marriage.

<table>
<thead>
<tr>
<th>Period (years)</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately after marriage</td>
<td>8</td>
<td>67</td>
</tr>
<tr>
<td>1-5 years after marriage</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>6-10 years after marriage</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>
It is evident from the table that the majority of the women (67%) were subjected to abuse immediately after marriage. Similar findings were reported by (Lawrence, 1984; Naidoo, 1992; and Padayachee, 1988). This table suggests that the abuse will start immediately after marriage and a year after marriage, and then persist.

PART B

4.3 PRE-TEST AND POST-TEST RESPONSES

4.3.1 Children's responses to the interview questionnaire

1. If a man hits a woman with a fist, is it abuse?

Table 9. Knowledge about physical abusive behaviour

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th></th>
<th>Post-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>83</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>17</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The participants knowledge about male abusive behaviour improved after being involved in the group therapy program. At post-test 92% of participants responded affirmatively as opposed to the 82% response at pre-test. This difference was noted even when the question relating to physical abusive behaviour was phrased differently (see question 2 and Table 10 responses).
2. If a man slaps a woman, is it abuse?

Table 10. Physical abusive behaviour

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Not sure</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The respondents knowledge about abusive behaviour increased at post-test. All of them 100% knew that slapping a woman is abusive behaviour as compared to the 75% response obtained at pre-test.

3. If a man calls names to a woman, is it abuse?

Table 11. Verbal abusive behaviour

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>Not sure</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The respondents knowledge of verbal abuse increased from 58% at pre-test to 83% at post-test.
4. If a man threatens to hurt a woman, is it abuse?

Table 12. Threats to hurt

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th></th>
<th>Post-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>83</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>17</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The children's knowledge of psychological abused increased substantially, from 83% at pre-test to 92% at post-test.

5. If adults in your house are fighting, what would you do to keep yourself safe?

Table 13. Safety strategies

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th></th>
<th>Post-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Call the police</td>
<td>8</td>
<td>67</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Lock in room</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Go to friends</td>
<td>2</td>
<td>17</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Hide</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

More children could identify appropriate strategies for handling emergency situations (such as calling police, go outside, go to friends) than before the group sessions (75% at post-test versus 67% at pre-test).
6. If someone tried to hurt your mother, what would you do?

Table 14. Intervention strategies

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th></th>
<th>Post-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Call the police</td>
<td>7</td>
<td>58%</td>
<td>9</td>
<td>75%</td>
</tr>
<tr>
<td>Try to stop/defend</td>
<td>2</td>
<td>17%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Call friends/family</td>
<td>3</td>
<td>25%</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100%</td>
<td>N=12</td>
<td>100%</td>
</tr>
</tbody>
</table>

At pre-test the majority of respondents reported that if adults were fighting, they would not intervene but call the police (58%). This attitude increased at post-test (75%).

7. Would you try to stop the fighting?

Table 15. Stopping the fight

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th></th>
<th>Post-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>25%</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>8%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>67%</td>
<td>11</td>
<td>92%</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100%</td>
<td>N=12</td>
<td>100%</td>
</tr>
</tbody>
</table>

The majority of children 92% reported that they would not stop the fight if adults are fighting. This indicates their increased knowledge of safe behaviour.
8. If there were fights in your family, who would you talk to?

Table 16. Communicating about fights

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Sibling</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mom</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Grandparents/uncles/Aunts</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>Police</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Teacher</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Friend</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of children indicated that they would talk to grandparents/uncle/aunts if there were fights in the family. This increased at post-test.

9. Some fighting and hitting (between a dad and mom) is acceptable.

Table 17. Physical attacks between parents

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>True</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Not sure</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The children's knowledge of abusive behaviour increased dramatically at after the group programme e.g. they all knew that fighting is not acceptable.
10. Alcohol or drugs cause woman abuse.

Table 18. Substance abuse causing woman abuse

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of the children 50% attributed the violent behaviour of their fathers to alcohol abuse by their fathers. This is consistent with the survey carried out by Lawrence (1984) among professionals at Mitchel’s Plain. In her survey, 72% attributed family violence of their fathers to alcohol abuse.

11. Sometimes the children are the cause of parents’ abusive behaviour/fights.

Table 19. Children being the cause of parental fights

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>True</td>
<td>7</td>
<td>58</td>
</tr>
<tr>
<td>Not sure</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>False</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

At pre-test session, the majority of children felt responsible for their parents’ fights but this attitude changed to 92% at post-test.
12. Children should try to stop parents from fighting.

Table 20. Children stopping parental fights

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>True</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>False</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of children’s safe behaviour during violent episodes between parents increased. At pre-test 75% felt responsible to stop the fight and 83% said ‘no’ to stop the fight at post-test.

13. When I am mad at someone, I always get help to settle the problem.

Table 21. Problem solving strategy

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Always</td>
<td>8</td>
<td>67</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of respondents, i.e. 75% stated that they would get help to solve a problem and none of them stated that she/he would never seek help.
14. When I am mad at someone I go away and cool off.

Table 22. Reacting by going away

<table>
<thead>
<tr>
<th>Responses</th>
<th>Pre-test</th>
<th></th>
<th>Post-test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Always</td>
<td>3</td>
<td>25</td>
<td>8</td>
<td>67</td>
</tr>
<tr>
<td>Sometimes</td>
<td>6</td>
<td>50</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Not at all</td>
<td>3</td>
<td>25</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>N=12</td>
<td>100</td>
<td>N=12</td>
<td>100</td>
</tr>
</tbody>
</table>

At pre-test, 25% of participants responded that they would always go away and cool off when mad at someone compared to 67% at post-test.

4.3.2 Children’s Evaluation: Post Group

1. How much did you like the group?

Table 23. Liking the group

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>A little</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Not at all</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of the respondents reported to have liked the group a lot (75%), and only few (8%) reported not to have liked the group.
2. How much did you learn in the group?

Table 24. Learning from the group

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>A little</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Not at all</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The majority of the children, 83% reported to have learnt a lot in the group. None of the respondents reported to have learnt anything from the group.

3. Would you tell a friend who has problems in his/her family to come to this kind of group?

Table 25. Marketing the group

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Not sure/undecided</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The majority of children 92% indicated that they could recommend group therapy to others. The comment below attests to that.
"I feel it really changed my life and I even told my friends at school who experience family problems to come to this group" (comment from a 12 year old boy).

4.3.3 Analysis of mothers’ interviews

1. How often were children present during family violence?

Table 26. Children’s presence during family violence

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>4</td>
<td>33</td>
</tr>
<tr>
<td>Often</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>Seldom</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

Examination of Table 12 indicates that in the majority of cases, the children had witnessed the violence between their parents. These findings concur with those of Lawrence (1984), who in her survey of 50 families, found that in 20 of the families the children were always present during the fight, and that in 19 families the children were often present. Similarly Gelles (1977) found that wife abuse generally occurred where there were only nuclear family members present. Husbands waited until no one was present other than the children because they (husbands) feared being labelled as abusers. Thus it appears that in instances of wife abuse, children invariably witness violence between parents.
2. What did your children do when you were arguing/fighting?

(coping strategies)

Table 27. Children’s reaction during family violence

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Frequency for boys</th>
<th>Frequency for girls</th>
<th>Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervene/try to separate</td>
<td>5</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td>Hide in the room</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Called police</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Helpless, cry, plead with father to stop</td>
<td>1</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>5</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

An examination of the above table indicates that in the majority of cases (67%), children intervened in the inter-parental violence. Some hide themselves away from violent parents and others call the police. A few children who used to intervene had sustained injuries which necessitated medical attention.

4.3.4 Mother’s Evaluation: Post Group

1. How much do you think the group has helped your child?

Table 28. Group’s contribution to child’s change

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>A little</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Not at all</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>N = 12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
The majority of parents (75%) reported positive changes in the emotional, behavioural, social expressiveness of their children following the group experience. Only minute percentage of the mothers (8%) reported no benefit from the group program. The comments below from mothers attest to this.

"It really made him feel very good about himself and also made him feel it is not his fault." (Mother of 11 year old boy).

"She seems more confident and happier, even stopped being aggressive to other children (mother of 13-year-old girl).

"We can talk freely about wife abuse and he seems more educated and freely talking about family violence. His attitude to family violence has really changed" (A mother of a 12 year old boy).

2. Have you noticed any positive change in your child as a result of participation in the group?

**Table 29. Degree of change in child after group participation**

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10</td>
<td>83</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Not at all</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>N = 12</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The majority of respondents 83% indicated to have noticed change in their children's behaviour in group therapy. The comments below support this.
“Nowadays he is more co-operative, sleeps well, he is not aggressive anymore, he listens a lot and even school work has improved” (mother of 13 year old girl)

“She is more confident and happier” (mother of 10 year old girl)

3. How much information did you receive about what your child was learning and doing in the group?

**Table 30. Information about the group**

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A little</td>
<td>11</td>
<td>92</td>
</tr>
<tr>
<td>Not at all</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>N = 12</td>
<td>100</td>
</tr>
</tbody>
</table>

The majority of the respondents (92%) reported to have received a little information about what their children were doing in the group. This was necessary to avoid parental influence on the outcome of the group program.

6. What would you suggest should be done differently in the future groups?

- More frequent group sessions
- Group therapy ongoing programme
- Include more children in group therapy
- Give parents more information on what is happening in the group
• Include parents in one session or separately
• Include individual sessions with the children
CHAPTER 5:

CONCLUSION

This chapter concludes the present study. In this chapter the main findings of the study, limitations and the implications of the study are discussed and finally directions for future research are noted.

5.1 SUMMARY OF THE MAIN FINDINGS AND DISCUSSIONS

This study established that the majority of children included in the study, from the Gold Field Family Advice Organization in Welkom, aged between 8 and 13 years, had witnessed spousal violence and had knowledge of what spousal violence is. Witnessing spousal violence had an effect on the children's coping strategies during conflict and violence, especially prior to group-therapy participation.

Children's knowledge about safe behaviour during violent episodes between their parents increased considerably after therapy sessions. For example, in response to the question, "If adults in your house are fighting, what would you do to keep yourself safe?" The majority of the children (75%) at Post-test mentioned calling the police and going to a place of safety well away from the fighting as opposed to pre-test responses where a minute percentage (17%) of the children mentioned going to friends. This was likely a result of the emphasis in the groups that the
first thing children should do in a situation of family violence is to keep themselves safe and get away from the fighting. Similarly, on the question, “If someone tried to hurt your mom, what would you do?” on pre-test 17% said they would defend mom in some way, while at post-test, this had decreased to 0% representing decrease of 17%. To the question, “Would you stop the fight?” 67% said “No” at pre-test, but 92% said “No” at post-test.

The majority of children improved their approaches to handling conflicts with peers and learned to use non-violent conflict resolution strategies. For example, the percentage of children who stated that they got help to solve a problem went from 67% at pre-test to 75% at post-test. Similarly, at pre-test, 25% responded that they would go away and cool off when mad at someone compared to 67% at post-test.

The majority of children improved their knowledge and attitudes with regard to responsibility for violence and stopped accepting excuses for violence, and also stopped believing myths about family violence. On the items, which dealt with definitions of woman abuse, the percentage of children regarding each act as abuse increased. For example, “Slaps”, 75% of children at pre-test and 100% of them at post-test defined this as abuse. Also, with regard to verbal abuse (“call her names”), 58,3% of the children at pre-test and 83,3% of them at post-test defined this as abuse. More children understood that children were not the cause of parents abusive behaviour and fights: 17% were clear on this at pre-test, and 92% after participating in the groups.
The participants' appraisal of the groups was positive, with regard to personal and psychological comfort in the group, as well as learning from the group. The children's appraisal of how much they liked the group was extremely positive. Seventy five percent of the children rated their liking of the group. Only a minute percentage (17%) rated their liking a little for the group. Also 83 percent rated their learning in the group as "a lot". Furthermore, the quality of the children's comments as to what they liked about the groups was quite detailed and often related to the central contents of the group, rather than to more peripheral factors.

The participants' mothers also appraised the groups positively, in terms of the participants' learning as well as, possibly, improvement in behaviour. The mothers' appraisal was positive. Eighty three percent of mothers rated their children as having changed as a result of the group, while only two (17%) noted this change to be in a negative direction. With regard to suggestions for change, these are listed in their entirety in the Results section.

It was interesting to note that the majority of mothers who experienced spousal violence were quite literate with 58% having secondary education and 25% tertiary education. This has serious implications on instilling awareness about spousal abuse to individuals who are also at the lower educational levels.
In this study spousal abuse was predominantly experienced in nuclear families. Apparent also was that in most instances women were subjected to abuse immediately after marriage.

5.2 IMPLICATIONS AND LIMITATIONS

5.2.1 Implications of the study

The major implication of the findings of this study is that children who witnessed family violence experienced multiple psychosocial problems and they have a need for group-therapy intervention.

It is also clear that professionals who deal with children from violent families need to be trained to be able to assist these children. This implies that inservice training and workshops need to be organized by the Welfare organization and other Community-based organizations for their children.

5.2.2 Limitations of the Study

5.2.2.1 Research Sample

It is important to bear in mind the limitations of the sample. All participants were children whose mothers came to the Gold Field family Advice Organization for counselling and advice. Most battered women do not seek advice or come to the
Family Advice Organization. Those who do come are likely to experience more serious battering and a lack of family support (Davis & Carlson, 1987). The possibility of the sample being biased exists in that only children of mothers seeking help were interviewed. Since in this study a convenience sample was used it, therefore, means that generalizations cannot be made from its findings.

However, this study was conducted within the existing Community organization, involving both children and their mothers, thus, similar studies can be replicated for purposes of comparisons.

Further, the researcher did not draw a distinction between children who were bystander's witnesses to spousal violence and children who have themselves been victims of abuse. This factor might have influenced the experiences of child witnesses to family violence. Despite these limitations, the researcher is convinced that the findings in this study would form a useful basis for the understanding of the problem, and perhaps for future projects in this field of study.

The absence of a control group is another weak point of the study, which limits the differentiation between treatment effects and spontaneous improvement over time. But because of the limited number of potential participants a control group could not be established.
5.2.2.2 Researcher bias

As human beings, researchers cannot be completely neutral because they carry with them political, religious, cultural, racial and ethnic attributes (Wagar & Roadway, 1995). The researcher was always trying to be aware of his own bias and acknowledge that one cannot be value free.

5.2.2.3 Respondents

Participants might have seen the researcher as an authority figure and might have felt obligated to cooperate (Peled & Edleson, 1992). To avoid this the researcher explained the purpose of the study and the fact that their participation was voluntary. The researcher also emphasized that they respond as honestly as possible. When participants feel threatened they tend to respond with what they think the researcher wants to hear.

5.3 RECOMMENDATIONS

While the state of research in this field of study is in its initial stages, and as more programs are developed, that rely on research findings, it is imperative that programs be designed and studied in culturally sensitive and appropriate ways.
More groups of this kind still have to be formed all over the country because of the family violence pandemic. Children who witness family violence need support.

It would be a further contribution and extension of the present study if the support groups with children who witnessed family violence from the general population could be implemented and evaluated. This would increase the generalization of the findings of the present study, thus avoiding only children of mothers who sought help.

It would also be of great help if future studies on child witness to family violence can draw a distinction between bystander witnesses to spousal abuse and those children who have themselves been victims of abuse.

Future studies would have to investigate whether the program could be taught to, and carried out by professionals from related professions (teachers, social workers) to guarantee a broad and cost effective applicability. General ability and long term effects should also be a focus of future studies.

The researcher strongly recommends that future research in this field, as children witness family violence all over the world, is in great need for appropriate psychosocial treatment addressing their requirements. It is observed that to date, there does not seem to be sufficient evidence for effective psychological and economic treatment programmes of the required nature.
Despite its many flaws, the present study indicates that group interventions for child witnesses to family violence have a positive impact on the psychological well-being of Black children. Improvements have been noted with respect to children's attitudes, social behaviour and some aspects of emotional functioning (i.e. Hughes & Borad, 1983; Jaffe et.al., 1986; Peled & Edleson, 1992; Wagar & Rodway, 1995; Wilson et.al.1989). Therefore, there is a necessity to urgently provide opportunities for group-therapy participation for these children, especially in communities with non-existent psychotherapeutic resources. The findings as given in this study can promote the understanding of psychologists, health care professionals and politicians of the beneficial role that group-work can play, in the enhancement of psychological and social wellness in children who witnessed spousal abuse. Information from research projects such as this one can support policy for better provision of resources in communities and the development of programmes with lasting psychotherapeutic relevance.

The present research was found to be in line with values and ideas of community psychology, which regards the whole community as possible clients. Some of the aims of community psychology are illness prevention and alleviation of problematic psychological symptoms through health promotion and empowerment. In this study, individuals, communities and community psychology professionals working in collaboration achieved this through social
action. The main goal was to improve human condition and promoting psychological well being. This was achieved by applying knowledge and methods of study, research intervention and evaluation from the broader disciplines of psychology and social sciences in community context.

It is the researchers hope that the present research has made a valuable contribution to health promotion of the child witness to family violence in particular and in general to the entire South African population (children), through the social action model.

This support group was nested within an existing community organization. Therefore, it is guaranteed that the structure will be left in place even if the researcher withdraws his participation.

In South Africa where moral, regeneration of youth and by implication health promotion is a priority on the government agenda, research findings such as those of this study can serve as an indicator for policy design and for the development of programmes in which psychotherapeutic participation could be a developmental asset. Such a developmental asset can serve as a protective factor to children who are at high risk in families or communities. This will not only prevent psychological dysfunction but can also promote the building of character strengths. Participation in group-therapy proves to be a powerful behavioural tool with which to accomplish the establishment of a positive well-being, both physically and psychologically.
REFERENCES


Child Care Act 74 of 1983. RSA.


   


Consent form for research participation

I ........................................................................................................ hereby declare that I willingly give consent for participation in the research as explained to me.

I was also informed that the identity of my child will be confidential and no personal name or identification data will be used in any publication.

I understand and duly accept that the information collected will be solely used for research purpose, publication in scientific journals, teaching as well as to improve methods of helping children who witnessed family violence.

I am also informed that the investigation and group therapy program will be conducted by the researcher T J Mamphekgo who is a Registered Clinical Psychologist. I declare that my permission is granted on my own will and can be revoked anytime during the process of the study; and that such action will not result in any negative bias to the therapy programme for my child.

Signed: ...........................................    Date: .........................................................

Witness: ...........................................    Date: .........................................................
APPENDIX B

**Mother's interview schedule**

**Families Information**

**Identification number:**

I would like you to answer some questions as honest as possible. This will give me some idea on how to go about in helping you and your family.

1. **Child's gender**
   - [ ] male
   - [ ] female

2. **Child's age**
   - [ ] 8-9 years
   - [ ] 10-11 years

3. **Child's Educational Level**
   - [ ] Grade 1-3
   - [ ] Grade 4-6
   - [ ] Grade 7-9
   - [ ] Grade 12-13

4. **Mother's age**
   - [ ] 20-29 years
   - [ ] 30-39 years
   - [ ] 40-49 years

5. **Mother's Educational Level**
   - [ ] Grade 1-7
   - [ ] Grade 8-12
   - [ ] Tertiary Qualification

6. **Mother's Occupations**
   - [ ] Housewife
   - [ ] Domestic
   - [ ] Labourer
   - [ ] Professional

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APPENDIX C

Children’s Interview Schedule

I would like you to answer some questions as honestly as possible. This will give me some idea on how to go about in helping you and your family.

1. If a man hits a woman (with a fist) is it abuse?
   □ Yes    □ Not sure    □ No

2. If a man slaps a woman, is it abuse?
   □ Yes    □ Not sure    □ No

3. If a man calls names to a woman, is it abuse?
   □ Yes    □ Not sure    □ No

4. If a man threatens to hurt a woman, is it abuse?
   □ Yes    □ Not sure    □ No

5. If adults in your house are fighting, what would you do to keep yourself safe?
   □ Call the police    □ Lock in room    □ Go to friends    □ Hide

6. If someone tried to hurt your mom, what would you do?
   □ Call police    □ Try to stop/defend    □ Call friends/family
7. Would you try to stop the fighting?
   □ Yes   □ Not sure   □ No

8. If there are fights in your family, who would you talk to?
   □ Sibling
   □ Mom
   □ Grandparents/Uncles/Aunts
   □ Police
   □ Teacher
   □ Friend

9. Some fighting and hitting (between a dada and mom) is OK.
   □ Yes   □ Not sure   □ No

10. Alcohol and drugs cause family violence.
    □ Yes   □ Not sure   □ No

11. Sometimes the children are the cause of parents’ abusive behaviour/fights.
    □ Yes   □ Not sure   □ No

12. Children should try to stop parents from fighting.
    □ Yes   □ Not sure   □ No
13. When I am mad at someone, I always get help to settle the problem

☐ Always  ☐ Sometimes  ☐ Never

14. When I am mad at someone I go away and cool off.

☐ Always  ☐ Sometimes  ☐ Never
APPENDIX D

Children’s programme evaluation guide

I would like you to answer some questions as honestly as possible regarding our programme. This will give us indications on whether we managed to assist you or not and what improvements to make if any?

1. How much did you like the group?
   - [ ] A lot
   - [ ] A little
   - [ ] Not at all

2. How much did you learn in the group?
   - [ ] A lot
   - [ ] A little
   - [ ] Not at all

3. Would you tell a friend who has problems in his/her family com come to this kind of group?
   - [ ] Yes
   - [ ] Not sure/undecided
   - [ ] No
APPENDIX E

Mother’s Programme evaluation interview guide

Please evaluate the group therapy program as honestly as you can. Your honest and fair feedback and views about the programme are very important to us as researchers. It will help us to know whether we have made impact on your child and what improvements to make, if any. We will highly appreciate your evaluation and comments. Please feel free and relaxed as you fill in the following questions:

1. How much do you think the group had helped your child?
   □ A lot □ A little □ Not at all

2. Have you noticed any change in your child as a result of participation in the group?
   □ Yes □ Not sure □ No

3. How much information did you receive about what your child was learning and doing in the group?
   □ A lot □ A little □ Not at all
4. What would you suggest should be done differently in the future groups?

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................